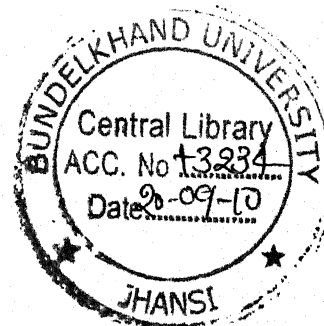


Social and psychological factors leading anaemia among rural women in Jhansi District



THESIS
Submitted for the award of the degree of
DOCTOR OF PHILOSOPHY
In
SOCIAL WORK

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2008

Certificate

This is to certify that the present work entitled, "Social and psychological factors leading anaemia among rural women in Jhansi District" has been carried out by Ankita Gupta under my direct guidance and supervision. Her observation has been checked and verified by me from time to time. She has put in more than 200 days attendance as per rules laid down.

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Preface

Poor health status of women in terms of high mortality and morbidity is a major health priority in the country health facilities through hospitals and health centre are provided in addition to number of special programme and scheme. Nutritional intervention like iron folic distributions etc. were implemented in the past to provide service in an integrated manner to the women who are vulnerable to anaemia. The child survival and safe motherhood programme was implemented in India since 1992.

Despite all these efforts the desired impact on the health of the women in the country could not be achieved. The prevalence of anaemia in rural areas of Jhansi ranges from 21% to 80% but it differs from region to region.

Women's socio-cultural situation and her health are very closely interrelated. A major factor underlying anaemia in rural areas is their low economic & social survival. Various socio-cultural factors affect women's health like financial status, education, religion, cultural mores and so on.

The lives of women in developing countries like India differ from those of men for cultural, and socio-economic reasons. These differences place women at significantly higher risk than men of malnutrition and mortality.

The importance of women's nutrition of their own health and quality of life. The present study "Social and psychological factors leading anaemia among rural women in Jhansi District" is an attempt to understand the magnitude and causes of the problem of anaemia with reference to rural area of Bundelkhand. It is particularly concerned to understand the

prevalence of anaemia in a village of Jhansi district which leads to many disease due to anaemia in a village of Jhansi district and impair the health of women.

The whole study was divided into 8th chapter which are given below.

- (i) First chapter deals with the introduction and objective of the study
- (ii) Second chapter highlights the review of literature relevant to this study.
- (iii) Chapter third discusses the research methodology.
- (iv) Chapter forth deals with the socio-economic and cultural profile of the rural women.
- (v) Chapter fifth discusses the major health problems of the village women and their nutritional status.
- (vi) Chapter sixth highlights the socio-economic and psychological cultural factors leading to anaemia among rural women,
- (vii) Chapter seventh
- (viii) deals with the evaluation of maternal & child health services and various welfare schemes initiated for the rural women.
- (ix) Chapter eight provides brief summary, conclusion and recommendation.

It is hoped that this study will be of some use to health administrator, sociologist, policy makers and researchers who are working on the subject. It provides wealth of information to any body who attempts to undertake similar kind of field investigation in future.

Acknowledgement

*In this connection I express my gratitude to my esteemed research guide **Prof. N.N. Awasthi**, Former Head, Dr. B.R. Ambedkar Institute of Social Sciences, Bundelkhand University Jhansi for his valuable and untiring help & guidance to me in preparing and submitting this thesis. Without his constant help it would have not been impossible for me to complete this thesis.*

*I also feel it my duty to express my gratitude to my beloved mother **Mrs. Usha Gupta** for her encouragement in going ahead with this work. Without her blessing and constant inspiration this work could have never been completed.*

*I am also indebted to my father in law **Mr. Narendra Gupta** & Mother in law **Mrs. Sita Gupta** for giving me permission to carry on my work. Despite inconvenience caused to them.*

*Lastly I am greatly in debted to my husband **Mr. Vikas Gupta** for his love and support. He kept me completely absolved of all domestic responsibility, so that I could concentrate on the work single mindely.*

*I would like to thank **Mr. Sumit Kumar** (Sumi Computer) for careful and neatly typing at the manuscript.*

In the ends I am thankful to all those who have helped me to complete this work.

Agupta

ANKITA GUPTA

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Chapter-1

Introduction



INTRODUCTION

A healthy mother is expected to give birth to a healthy and normal child, further more, children born to malnourished mothers remain, at a high risk of developing malnutrition, thus by improving health status of women a corresponding improvement in the health of new born can well be expected.

Among various nutritional disorders affecting women of child bearing ages all over the world, anaemia holds a top position. It is known to cause widespread ill effects on the pregnancy and its outcome.

Diet and nutrition are important factors in the promotion and maintenance of good health throughout the life cycle. A normal balanced diet must include daily foods from the various food groups in sufficient amounts to meet the needs of an individual. Health and nutritional status of individuals depends on the food she eats. The components of the diet must be chosen judiciously to provide all the nutrient needed in adequate amounts and proportions. Food stuffs selected from each group should take into account the income, socio-cultural factors, availability and nutritional requirement, selection of foods from the different food group also results in variety in the diet,

which not only ensures nutritional adequacy but also increases food acceptability. It was reported by Zive et al., (1996) that deficient intake of essential nutrient such as calcium , iron, magnesium, zinc, folate, vitamin A, Vitamins B₆, Vitamin C were found more in large proportion of young women than young men. A faulty diet can certainly be a source of stress and this leads to the formation of poor dietary habits. Women with deficiencies of folic acid and other vitamins are an increased risk of cardio vascular diseases.

Amongst various nutritional disorders affecting women of child bearing ages all over the world, anameia holds a top position. It is known to cause widespread ill effect on the pregnancy and its outcome.

All the iron needed for the biological function comes from diet. Although cereal pulses based diets are regarded as good sources of iron, the non-home iron present is relatively poorly absorbed.

Nature and magnitude of Anaemia in rural women W.H.O. sponsored studies (WHO, 1968) indicated that prevalence of anaemia in rural women in different parts of world, ranges from 21% to 80% the highest being in India. These studies further indicate that prevalence rate of anaemia not only differs between countries but also between region within a country.

Haemoglobin estimation is considered as a most practical method of diagnosis. It is most effective and could be performed by well trained technician. The cut off level of haemoglobin to anaemia is not standardized all over the world. In India some consider cut off level of haemoglobin as 8 g and other consider 10 g as cut off point. The guidelines of WHO consider any haemoglobin less than 11 g/dl in pregnancy as anaemia . We feel that WHO standard definition should be accepted all over the world. This would help in comparison of data from one centre to another. Ideally it is important to know total circulating haemoglobin mass. It gives exact idea about haemoglobin status of the person. But estimation of total circulating haemoglobin is not very simple. It requires more expertise and costly equipment. Rapid loss of blood as in haemorrhage would reduce total haemoglobin mass but haemoglobin concentration would not be affected immediately. In chronic nutritional anaemia, haemoglobin concentration underestimates the severity of anaemia because in chronic nutritional anaemia, there is reduction in red cell volume while plasma volume remains constant. Therefore, in spite of these limitations, estimation of haemoglobin-concentration per 100 ml of blood remains practical method to diagnose anaemia.

There are several methods for haemoglobin estimation. The Tallquist's method of haemoglobin estimation has simplicity and easy

applicability. However, it does not provide accurate, replicable estimate of haemoglobin. The copper sulphate method though simple, has many drawbacks and is not reliable. Sahili's method is reliable and accurate when done by experts. However, it has not proved reliable when done by paramedicals and half-trained technicians. At present cyanmeth-haemoglobin method appears to be most reliable. Unfortunately, this method is not very popular even in teaching institutions. Sahli's method is used largely at most centres.

Iron deficiency anemia is one of the most common nutritional disorders world-wide, especially in India and other developing countries, young children and women in the reproductive age group are most vulnerable to iron deficiency anaemia.

Surveys in different parts of the country reveals that 87% of pregnant women suffers from anaemia and about 10% have severe anaemia ($H < 80$ g/l). Variation in the prevalence rates of anaemia are seen within the country with the lowest prevalence of 33% being reported from Andhara Pradesh to highest of 98% in Rajasthan,. Severe anaemia is an important risk factor in pregnancy, report from India indicate that 16% of all maternal deaths are attributable to anaemia.

Anaemia is one of the most widespread nutritional deficiency disease. It affected all age groups and both sexes in most states of India. Profoundly affect groups are adolescent girls (74% to 98%). Pregnant women (82% to 98%) and women in childbearing age (74% to 99%).

Sood (1967) compared to prevlance of anaemia in three groups of women viz. (a) 504 pregnant women from co-operation, maternal and child welfare centre New Delhi, (c) 106 women of a rural area of Delhi. It was observed that in these three groups the prevalence of anaemia varied significantly, being 27.3, 43.0 and 47.0% in a, b, & c groups respectively.

Nutritional Anaemia is a world wide problem with the highest prevalence in developing countries it is found especially among women of child bearing age, young children during pregnancy and lactation. It is estimated to affect nearly two third of pregnant and one half of non-pregnant women in developing countries. The population of developed countries are not by any means completely free of anaemia and a significant percentage of women of child bearing age (estimated between 4 & 12 percent) suffers from anaemia.

In India anaemia is a major nutritional problem and in many other developing countries. In addition, many subjects have iron

deficiency without anaemia. The incidence of anaemia is highest among women and young children varying between 60% to 70%. Recent survey indicate that in rural India anaemia is much more widespread than higher to be believed even among man.

In India IMR (imfant mortality rate) is 61 per live birth. In India maternal mortality rate per 1000 live birth is current level 407. In Uttar Pradesh there are 707 MMR (maternal mortality rate) per 100,000 live births.

The major causes of MMR during the year 1998 were anaemia (19%) in India.

Various surveys have been conducted in Bundelkhand region and it has been found that 70% of the women in the rural area of Bundelkhand suffers from anaemia.

In order to prevent nutritional anaemia among mothers and children (1-12 year) the Govt. Of India sponsored a National Nutritional Anaemia Propphlaxis programme during the forth five year plan. The programme is based on daily supplementation with iron and folic tablet to prevent mild and moderate cases of anaemia the beneficiaries are 'at risk' group viz. pregnant women lactating mothers and children upto 12 years.

MCH (mother and child health) is not a new speciality. It is a method of delivering health care to special group in the population which is especially vulnerable to disease, disability or death. These groups (i.e., children under the age of 5 years and women in the reproductive age group (15-44 years) comprise about 31.6 per cent of the total population in India (75).

The MCH services encompass the curative, preventive and social aspects of obstetrics, paediatrics, family welfare, nutrition, child development and health education. The specific objectives of MCH are:

1. Reduction of morbidity and mortality rates for mothers and children
2. Promotion of reproductive health, and
3. Promotion of the physical and psychological development of the child within the family.

Though concerned with child development and the health education of parents and children, the ultimate objective of MCH services is life-long health.

The components of MCH include the following sub-areas

- a. Maternal health
- b. Family planning
- c. Child health
- d. School health
- e. Handicapped children
- f. Care of the children in special settings such as day care centres.

The content of MCH care will vary according to the demographic, social and economic patterns. Factors such as urbanization, rural migration, changing patterns of women's work and status have far-reaching effects on childbearing and child-rearing. It is now generally accepted that the MCH services should always be flexible and based on, and adapted to the local needs and resources of the community it serves; they should be moulded to the local traditions, cultures and other environmental characteristics and cannot be modelled on patterns copied from other countries. Health care, social legislation and social support measures also will have to be adapted to these changing needs and problems of the community.

MCH care is now conceived of as all activities which promote health and prevent or solve health problems of mother and children, irrespective of whether they are curative, diagnostic, preventive or rehabilitative, and whether they are carried out in health centres or in the home by primary health care workers, traditional dais, or highly trained specialists.

Maternal and child care was traditionally designed and provided in the form of vertical programmes with standard technical content based on models from a few developed countries. Applied in different socio-economic situations, such vertical programmes have been unable to provide more than minimum coverage because of their cost, and they have scarcely been of a kind to solve the priority problems of the majority of mothers and children. The emergence of some new concepts is now changing the organization and management of MCH care in increasing number of countries.

Conventional MCH services tended to be fragmented into antenatal care, postnatal care, infant care, family planning etc. The various components were dealt with separately by different staff or departments. This approach has changed over the years. The trend now is towards an "integrated" approach. This integration is based on the fact that it is inconvenient for the mother to go to one place to receive

care for herself, to another for care for her children and yet another for family planning services.

An integrated approach implies that all those involved in maternity care from the obstetrician down to the local dai, must work as a team. Obstetric and paediatric units should be closely linked so that there can be regular contact between obstetricians, paediatricians, community physicians, health and social workers so that services for the care of the mother and the child in the hospital and community be planned and reviewed including teaching and research. This approach will help to promote continuity of care as well as improving efficiency and effectiveness of MCH care.

A new and promising means of improving the coverage and efficiency of MCH care and family planning is the "risk approach". This is a managerial tool for factor use of scarce resources. It is based on the early detection of mothers and children with high risk factors. All mothers and children with high risk factors are given additional and more skilled care including hospitalization, while at the same time essential care is provided for the rest of the mothers and children so that every one gets care appropriate to their need.

It is also possible to assess the "degrees" of risk of each factor, by scoring according to their (a) magnitude - i.e., extent and severity;

(b) testability - responsiveness to treatment and control; (c) cost effect - in terms of alleviating woman suffering; and (d) community attitude - social concern. Such an approach when applied on a community-wide basis enables the determination of priority activities, within the MCH programme based on the "degrees" of risk.

Application of the risk approach to the problems of mothers and children is a departure from past or traditional practices to promote the health of mothers and children.

If one is to identify one strategy that would change. The tide of maternal deaths, it would be female literacy and socio-economic status. Female literacy and maternal mortality are intertwined in an inverse relationship. Improving the former will reduce the latter. Educating women allow them to take better charge of themselves. It improves their economic power and a better social and legal status follows. All these decrease sex-gender biases, the single most important link between sociological and medical contributions to maternal deaths. In countries where women are the 'lesser sex', their persecution starts inutero. Female foetuses are preferentially aborted; if born, girls are considered a liability rather than an asset. They are underfed, overworked (with no economic reward) and take second place to the

boys for education and health care. They, start their child bearing career early and have many children, only to produce family heirs (boys).

The girls born to these women will suffer a similar plight. Education can liberate such women from this vicious cycle. Improving female literacy and lowering sex-gender biases lead to better health seeking behaviour amongst women, greater contraceptive use and more liberal utilisation of available health resources. The education can be delivered by both formal and informal means. Countries should be encouraged to enrol girls into primary and preferably secondary schools as well. Apart from the usual curriculum, girls should be taught general hygiene, reproductive health and contraception. This formal education will have a multiplier effect in that important messages can be carried home to less literate parents. Equally useful are informal and novel methods of education: Although a major proportion of girls in developing countries have no formal 'western' education, many may have access to religious teaching centres. Opportunities should be seized to involve these religious organizations to help deliver necessary lessons in reproductive health. Much of the teaching can be done by female volunteer teachers; many would find this more acceptable. The media and non-governmental volunteer organizations (NGOs) too can

adopt this social responsibility towards a common goal of improving the fate of lot of women in many developing countries.

Iron fortification, the W.H.O. Experts (49) did not recommended iron fortification strategy for control of anaemia in region where its prevalence is high.

There are other instances such as changing dietary habits control of parasites and nutrition education. These are long term measures application to situation where the prevalence and severity of anaemia are lower cost and time involved to meet the desired goals through strategies are dis proportionally high.

For the mother package of service are immunization prevention and treatment of anaemia, antenatal care and early identification of maternal complication, deliveries by trained personal promotion of institutional deliveries, management of obstetric emergencies, birth spacing.

Women are more vulnerable to anaemia because their needs of iron are greater then those of adult men. Women having closely spaced pregnancies are particularly at risk 2.

National nutritional anaemia prophylaxis programme has been in operation for a number of years. The programme aims at provision of

iron and folic acid supplements to the 'high risk' group identification and treatment of severely anaemia cases and promotion of the consumption of iron and promotion of the consumption of iron rich food. Change in dietary pattern is a long term strategy for prevention of anaemia.

Severe anaemia in pregnancy is associated with increased risk of maternal mortality causing an estimated 80,000 maternal deaths every year, high incidence of premature delivery, low birth weight, perinatal mortality and foetal wastage.

Severe anaemia is important risk factors in pregnancy. Reports from India indicated that 16% of all maternal deaths are attributable to anaemia. Maternal anaemia also contributes to an increase in perinatal mortality, low birth weight and foetal wastage.

In the past, several studies have shown that iron deficiencies anaemia often leads to irreversible impairment of the Child's learning ability and behavioural abnormalities.

Such losses are proportionally less in women (0.7 to 0.8 mg/d). menstrual bleeding causes an additional loss of 0.4 to 0.5 mg iron daily amounting to a total loss 80 μ g/Kg/day. Women also lose iron to the placenta and the foetus, amounting to about 1.3g of iron as the cost of normal delivery.

Generally the rural women are suffering from anaemia due to imbalance diet and lack of awareness.

Medically speaking Anaemia is considered as a condition of reduction in the concentration of haemoglobin in the peripheral blood the normal for the age and sex.

According to Erslev (1977) it is a condition characterized by haemoglobin concentration below normal level which the patient suffers from tissues hypoxia due to low oxygen capacity of the blood.

A WHO expert group proposed that, "Anaemia of deficiency should be considered to exists" when haemoglobin is below the levels.

Anaemia, due to iron deficiency is particularly common in women of the reproductive age group and young children. Surveys of haemoglobin levels of population in different area reveals that 88% among pregnant women suffers from anaemia and about 26% have severe anaemia.

The term anaemia has been defined as disminution in the oxygen carrying capacity of blood or in other words dissimulation capacity of blood or in other words, diminution below normal in the total circulating haemoglobin mass. The haemoglobin concentration is accepted as one or the indicators for the qualitative and quantitative assessment of anaemia in general, "Degrachy", defined anaemia as 'a

condition of reduction in the concentration of haemoglobin in the peripheral blood below normal for the age and sex of the patient various attempt have been made to classify from time to time.

Since then, there have been several report of the various retinal manifestations seen in anaemia,. In a major study of 152 anaemia patients. "Holt" attempted to define the incidence of retinopathy in the various disorders of blood. Whether lesion were of any diagnostic importance, and whether these abnormalities could be related to blood counts and prognosis. He found that 51 patients have retinopathy, which was diagnostic of the underlying anaemia.

Blood contains a fluid called plasma that includes three different types of cells. White bloods are port of the bodies immune system and defined it against infection.

Red blood cells are produced in the bone marrow vast quantities (million) of new cells are produced each day to replace old cells that break down. Nutrient from food, such as iron and certain vitamins, insure that your bone marrow remains healthy and is able to produce a constant supply of red blood cells.

The red blood cells rely on iron to help them store and carry oxygen to every part of the body. If there is a lack of iron in your blood, your organs and tissues will not get as much oxygen as they usually do.

Anaemia is a condition which there is a reduced number of red blood cells or haemoglobin concentration.

There are several different types of anaemia, and each one has a different cause. The most common form of the condition is iron deficiency anaemia. This is where your body lacks enough iron to keep the red blood cells functioning properly.

Iron is key component of haemoglobin, the substances which helps to store and carry the oxygen in red blood cells. Without enough iron, your blood cells will be able to carry less oxygen to all of the body's tissue and organs.

Other forms of anaemia can be caused by lack of vitamins B₁₂ or folate in your body. This health encyclopedia topic concentration on iron deficiency anaemia. For more information about vitamins B₁₂ and folate deficiency anaemia, see 'anaemia', vitamins B₁₂ and folate deficiency in the 'related articles' section.

Treatment for iron deficiency anaemia is usually very effective and the condition rarely causes and serious complication your blood may need to be monitored every few months after your diagnosis, to check that your are responding to treatment and that your iron levels returned to normal.

The end of iron deficiency is nutritional anaemia which is not disease entity. It is rather syndrome caused by malnutrition in its widest sense. Besides anaemia, there may be other functional disturbance such as impaired cells – mediated immunity, reduced resistance to infection increased morbidity and mortality and diminished work performance. Vitamins B₁₂ deficiency is associated with megaloblastic anaemic, demyelization neurological lesion in the spinal cord and infertility. Dietary deficiency of B₁₂ may arise in subjects who are strict vegetarians and eat no animal product. Nutritional anaemia affect all age groups.

Through some studies on anaemia and its various associated epidemiological factors have been carried out so far, however the literature on the subject is still very scanty. Further, studies from developing countries like India, where anaemia of pregnancy poses a great problem have been very few.

The most common symptoms of iron deficiency anaemia include.

- Tiredness
- Lethargy
- Shortness of breath and
- Palpitations (irregular heart beat)

Less common systems of iron deficiency anaemia includes :-

- Headache
- Ringing in your ears
- An altered sense of taste
- A desire to eat non-food items, such as ice, paper or clay (pica).
- Sore tongue and
- Difficulty in swallowing

You may also notice changes in your physical appearance, for example, signs that you may have iron deficiency anaemia include

- Pale complexion
- Abnormally smooth tongue
- Painful ulcers on the corners of your mouth.
- Dry flaking nails and
- Spoon shaped nails

Many people with iron deficiency anaemia will only display a few signs or symptoms of the illness. The severity of your symptoms may also depend on how quickly your anaemia develops. For example, if your anaemia is being caused by a chronic slow loss of

blood such as a stomach ulcer then you may notice very few symptoms, or they may developed gradually.

Amongst various studies it has been found that anaemia is a general indicator of poor health and it is closely linked with poverty and malnutrition.

Social factors of maternal mortality are age of child birth, purity too close pregnancy family size, malnutrition, poverty illiteracy, ignorance & prejudices, lack of maternal services, storage of health, manpower, delivery by untrained dais, poor environmental sanitation, poor communication & transport facility, social customs etc.

Pregnancy anaemia is emerging as a most important cause of maternal morbidity and mortality in all developing countries. Indian data show that at least 50% of pregnant women are anaemic¹. Anaemia results in intra-uterine growth retardation, small babies, preterm labour and increased risk of sepsis. The pregnancy anaemia is largely nutritional in origin. The pregnant woman becomes anaemic because of increased demand of iron during pregnancy, pre-existing negative iron balance due to frequent pregnancies, menstrual blood loss, dietary inadequacy, helminthiasis, etc. The nutritional anaemias are largely due to deficiency of iron and folic acid.

Iron deficiency and iron deficiency anaemia are not synonymous. In fact anaemia is a very late manifestation of iron deficiency. The individual is born with minimal or nil iron stores. The body starts storing iron after birth and it is estimated that storage iron in man reaches 800-1000 mg by the time he reaches adulthood. In female the storage iron is 400-600 mg only. This storage iron helps in times of crisis and maintains haemoglobin values to normal level. In India and in many developing countries, women are not able to build their iron stores because of poor nutrition, repeated infections, menstrual blood loss and repeated pregnancies. A study of serum ferritin levels in resident doctors, nurses, male resident doctors and pregnant women was undertaken. Serum ferritin is a very sensitive index of iron stores. Serum ferritin levels below 20 ng/ml suggest severe depletion of iron stores.

The study showed that serum ferritin levels were less than 20 ng/ml in 60% of pregnant women, 55% of nurses and 40% of lady doctors. Only 10% of the male doctors had the serum ferritin levels below 20 ng/ml (Table 1). The data clearly show that most women have very meagre iron stores and results in overt iron deficiency in conditions with increased demand of iron. It is important to diagnose iron deficiency in its early so that treatment could be initiated in time.

Table - Showing Serum Ferritin Values

Serum Ferritin (mg/ml)	Nurses (n=40)	Lady doctors (n=30)	Male doctors (n=30)	Pregnant women (n=40)
Up to 10	6	6	nil	10
11 - 20	16	7	5	13
21 -30	8	7	2	7
31 +	10	10	23	10

Dietary factors is also very important factor of anaemia. In dietary factor including dietary habits Upadhaya (1994) observed that there was no cases of anaemia in the non-vegetarian group, which used meat, fish stuff in additional to vegetable diet.

A study of dietary intake in Gauri village of Lucknow (Singh et al., 1971) revealed that the majority of the population was vegetarian consumed hardly any flash food.

Dietary inadequacy is the main cause for the high prevalence of vitamins A deficiency and iron deficiency, characterized by poor iodine deficiency, characterized by poor iodine content in soil leading to deficiency of iodine in food and water is responsible for IDD.

Maternal malnutrition delayed and inadequate supplementation, frequent childhood infections, avoidance of micronutrient – rich foods due to ignorance as a result of high female illiteracy, poor bioavailability of dietary iron and low purchasing power of families are the important causes of vitamins A and iron deficiency.

Iron deficiency anaemia occurs when the body does not enough iron. A lack of iron in your body can be caused by a variety of factors. Some of these factors are outlined below.

- Gastrointestinal blood loss : Bleeding in the stomach and intestines is the most common cause of iron deficiency anaemia in men, and is also the most common cause for women who have been through the menopause.
- Non-steroidal anti-inflammatory drugs (NSAIDs) : If used for a prolonged period of time, in high doses, NSAIDs can sometime cause bleeding in the stomach. Ibuprofen and aspirin are example of commonly prescribed NSAIDs.
- Stomach ulcers :- A stomach ulcer can occasionally cause your stomach lining to bleed. In some cases, this may cause you to vomit blood, or to pass blood in your stools. However, if the ulcer is slow symptoms, you may not display these symptoms.

Either way, the blood loss from the stomach can cause your to develop anaemia.

- Cancer : If your GP suspects that cancer may be a cause of your gastrointestinal bleeding, you will consult specialist for a more through examination. This way , if cancer is found, it can be diagnosed and treated as quickly as possible.

Menstruation : Menstruation is the most common cause of iron deficiency in women who have yet to go through the menopause. Usually only women with particularly heavy periods develop iron deficiency anaemia. If you have heavy bleeding over several consecutive menstrual cycles. It is knows as menorrhagia.

Pregnancy : It is very common for women to develop iron deficiency during pregnancy . this is because your body needs extra iron so that your body has a sufficient blood supply and received all of the necessary oxygen and nutrient. Many pregnant women require an iron supplement, particularly from the 20th weeks of pregnancy.

The time interval between an obstetric emergency and death is a complex interplay of Sociocultural, logistics and health service factors. The low status of women makes their illness low on the family priority list especially when financial and opportunity costs are

involved, thus delaying the decision to seek care. The woman even when educated, is unlikely to be the decision maker when she herself is sick or moribund and she has to depend on the whims of the real decision makers like her mother-in-law or husband. Hence the husband's education becomes an important determinant in survival. Cultural perceptions about illness also play a role in delayed treatment seeking eg, in certain communities in West Africa prolonged labour is considered a sign of the woman's infidelity to her husband and in many parts of western India, PPH (postpartum haemorrhage) signifies cleansing of the body by removal of bad blood.

Cultural factors are modified by practical considerations like the distance from the health facility, and the effort and time that would have to be expended in reaching there. Perceptions about the efficacy and quality of the care that will be received also determine utilisation. A study done in the USA found a very high maternal mortality rate (92 times higher) in a religious sect which does not believe in using modern obstetric care. This was despite the fact that the community is affluent and well educated.

Most nutrition interventions in developing countries have been designed primarily to reduce malnutrition among children. Even

programmes which include women tend to focus on pregnant and lactating women. This approach limits the success of interventions since action to improve nutrition-related reproductive outcomes is most effectively implemented before women become pregnant, and preferably should be undertaken before girls reach reproductive age. The different circumstances of men and women in developing countries affect women's nutrition, and it is necessary to take such differences into account when designing nutrition interventions. The major nutritional deficiency diseases of concern in the developing world are protein-energy malnutrition (PEM), iron deficiency anaemia, iodine deficiency disorders (IDDs), and Vitamin A deficiency. All four show gender differentials in prevalence and severity, with three of the four representing a more serious problem for women than men: the prevalence of PEM is significantly higher among women in South Asia (where almost half of the world's undernourished people lives); both iron deficiency anaemia and goitre are more prevalent among adult women than men, although vitamin A deficiency appears to be more prevalent among boys than girls. A dearth of good epidemiological data on adult nutritional status, and lack of appropriate reference standards, make it difficult to estimate accurately the extent of malnutrition among women in the developing world. Conservative

estimates suggest that of the 1130 million adult women living in developing countries in 1985, over 500 million were anaemic due to iron deficiency, almost 500 million were stunted as a result of childhood PEM, about 250 million at risk of disorders due to severe iodine deficiency, almost 100 million suffering from goitre, and almost 2 million blind due to Vitamin A deficiency. A problem of this magnitude cannot be dealt with through narrowly targeted feeding programmes for pregnant and lactating women, or by relying on the long-term effects of economic development programmes.

Data from 32 studies examining PEM among women in developing countries established that women generally consumed only about two-thirds of the WHO recommended daily allowance for energy, and that their average weight-for-height was well below the average for small-frame women in the US. Other studies have³² established that the energy-intakes of pregnant and lactating women only marginally exceed those of nonpregnant, nonlactating women. The long-term negative reproductive consequences of childhood PEM are fairly widely accepted. It is well established that stunted women are at higher risk of obstructed labour, itself a major cause of maternal mortality.

Iron deficiency anaemia is the most widespread nutritional problem among women, and has severe consequences for both their reproductive and productive roles. Maternal mortality rates are significantly higher among anaemic women, as are prematurity and infant mortality rates. Although there is limited direct evidence concerning the effect of anaemia on women's physical work capacity, research on men shows a clear association between iron deficiency anaemia and reduced work capacity. Because low-income, rural women living in the tropics experience the highest rates of iron deficiency anaemia (along with other forms of malnutrition and morbidity, and also some of the most physically demanding work responsibilities (including weeding, threshing, pounding, fetching fuel and hauling water), it is probable that anaemia among women accounts for a significant loss of productivity, and therefore of family welfare, in developing countries.

Iodine deficiency disorders are of particular concern since they can result in severe negative reproductive outcomes for both mothers and infants. Evidence from 19 studies shows that prevalence of goitre appears to be higher among women, with the gender differential first appearing in adolescence and becoming much more pronounced among adults. Severity increases in women with increasing age, but

declines significantly in males after adolescence. Although the reasons for higher prevalence and greater severity of goitre among women are not well understood, similar patterns in developed and developing countries suggest that at least part of the reason can be attributed to biological differences, perhaps aggravated by socioeconomic or behavioural factors.

Adolescent mothers are more likely to have low birthweight infants. This is due to a combination of shorter average maternal height, competition for nutrients between the still-growing mother and the fetus, and poorer placental function in adolescents. Interestingly, adolescent mothers need to gain more weight than older mothers to have a normal weight baby. Concurrent pregnancy and growth in low-income adolescent girls also has a significant negative effect on the micro-nutrient status of these mothers.

Two aspects of the status of women appear particularly relevant as probable indirect determinants of their nutritional status. The first is the cultural importance of childbearing in terms of a woman's status and her fulfilment of family expectations. In developing countries, women are usually under considerable pressure to bear children, sometimes to the extent of having as many, closely-spaced children as

possible. Another aspect affecting nutritional status is gender bias (where it exists) in intrahousehold food distribution. Some studies, based primarily on data from South Asia, have found less adequate consumption of nutrients on the part of adult women compared with men. While lower requirements may provide a partial explanation, it is unlikely that they account for all or even most of the generally poorer dietary intake of women, particularly since women often work longer hours and/or do more strenuous work than men.

Food proscriptions also affect women's nutritional status. Most societies have recommended dietary practices for pregnancy and lactation, and there is evidence from numerous cultures that meat and other high-protein foods are withheld, sometimes from women in general but most frequently from pregnant and lactating women. Women may themselves restrict their food intake during pregnancy to reduce fetal size and facilitate delivery. The effects of these practices on women's nutritional status are not known.

The lives of women in developing countries differ from those of men for cultural, biological and socioeconomic reasons. These differences place women at significantly higher risk than men of malnutrition and mortality. The importance of women's nutritional

status to their own health, productivity, and quality of life, and to the survival and healthy development of their children and other family members who depend on women's domestic and market work, warrant serious efforts to reduce malnutrition among women.

Inadequate nutrition in women is often a function of gender biases in access to food and health care. Where early marriage is practised, this deprives women of the benefits of education and the nutritional awareness it may bring. Poor women in India and Pakistan are often exposed to the double energy demands of gruelling agricultural work along with early and frequent childbearing.

Studies in Punjab, India, show that social discrimination against young girls in nutritional matters has persisted despite agricultural growth and economic development in the area. Even in privileged families, some girls may be malnourished. Indeed, the gender differential in food consumption among children from birth to four years was higher among landed classes than in landless families, with evidence of selective discrimination against daughters of second or higher birth order. This suggests that demographic transition in the region has worsened the status of female children, since their mothers continue to be under great pressure to bear and nurture sons. In West

Bengal, general village improvements have resulted in better nutritional status for boys, but not for girls. Additionally, women receive a disproportionately small share of household food, despite their greater energy expenditure on household and farming activities.

Gender differences in women's childcare and feeding practices are established early. Girls are breast-fed less frequently, for shorter durations, and over shorter periods than boys. Weaned early, they may not receive sufficient quantities of supplementary food. Documentation of the quality of food in several cultures has shown that male children generally receive more cereal, fats, milk and sugar than female children. Higher calorie and protein intakes by males of all ages have been documented for Bangladesh. Girls' lower levels of health care, combined with differences in feeding patterns, expose them simultaneously to higher rates of malnutrition and longer periods of more severe morbidity, contributing to their significantly higher mortality.

Low food intake during pregnancy is common in both India and Pakistan. Studies have shown that women consume little or no extra food during pregnancy, and may even consciously limit their intake for fear of large fetuses and difficult labour. Food taboos not only deprive

women of protein and iron sources, but also reduce calorie intake. In both countries, very high female mortality has led to an abnormally low female to male sex ratio 933 and 904 women per 1,000 men respectively in 1981. Seasonal shortfall in food availability tends to affect women disproportionately since their already inadequate intake will be curtailed drastically. Even when more food is available, it tends to be preferentially allocated to men, thus preventing women from accumulating any reserves. If seasonal shortfall coincides with pregnancy or lactation, the implications for women and infants are particularly harsh. These deep-rooted social prejudices are also seen in relation to women's access to and use of health services. One study found that while females outnumbered males four to three among children suffering from kwashiorkor, over 50% of related hospital admissions were boys. A survey in Maharashtra revealed that although higher percentages of girls were ill than boys, lower percentages received medical treatment in the under-15 age-group. Girls tend to be taken to less qualified doctors than boys, and have less spent on medicine for them. In general, better and more timely medical care for boys may be the main factor accounting for the higher survival rates among males.

These trends demonstrate that households discriminate against female children in relation to health care in much the same way that they do in nutritional matters. These patterns continue in adulthood. A larger proportion of adult women than men receive no treatment, and women tend to be treated mainly through home remedies or traditional medical care, while men receive institutional care. Hospital, clinic and primary health centre records in India and Pakistan invariably show that a greater number of males than females receive treatment as many as five times more. Female illness is, however, frequently underreported due to women's reluctance or inability to seek medical care, or deliberately downplayed due to constraints such as time, expense, or stigma. This can become a vicious circle as untreated female illness causes increased morbidity.

As women continue to bear the brunt of the hard labour in poor countries, it is important to foster the concept of improving women's nutrition and health for the sake of women themselves, rather than just for that of their children. The nutritional status of women during adolescence could be improved considerably, with spin-off benefits for their future infants. In the short-term, supplementary meal programmes for adolescent girls could have long-lasting benefits, while in the long term, structural and cultural changes are needed.

It is now acknowledged that malnutrition does not affect all members of a household equally, except in times of famine. Food is not equally divided within households, but reflects the order of precedence and perceived social value of the consumers, as well as factors such as religious practices. Studies of food distribution in both developed and developing countries note that food distribution based on sex differences always favours males. Unequal food distribution is further suggested by differences in morbidity and mortality within households. Effective development interventions therefore require knowledge of household resource allocation patterns. This is important given the heavy workload borne by poor women in both rural and urban settings.

Preferential food distribution refers to increased quantity and/or quality of food, as well as less obvious factors such as serving priority. In many societies, it appears that behaviour rather than absolute quantity of available food determines nutritional status.

Distribution of food usually favours males as their economic contribution is thought to be greater. Some children may receive preferential treatment based on their anticipated future contribution to the household. In Nepal, existing evidence points to age, sex, and

perceived current and future economic contribution as the primary individual characteristics determining intrahousehold food allocation patterns. This investigation of patterns of food distribution within households was carried out in six ethnically diverse hill villages in rural Nepal, using both anthropological and nutritional science methods.

In most of the households surveyed, the food servers were adult women. Young children tended to be served automatically, but those aged between 7 and 10 years served themselves more often than they asked for food. Food serving methods varied substantially by sex from early adulthood. Men, unlike women, were served automatically and with increasing frequency. This trend continued into old age. Women were much less likely to be served, and usually served themselves. Guests were frequently required to eat second helpings, whereas lower status household members had to ask for more. This becomes important when there is little food available for second helpings. Second-helping scores for young women were particularly low, leaving them nutritionally vulnerable at an age where they marry and move into their husband's home. There they have very low status; as junior females in the household, they are served automatically but are expected not to ask for food. When their status rises to that of food

server, their access to food increases. The server's access to leftover foods from other household members also contributes to their score.

Senior males were observed to receive large portions of a desirable food while adult women received a disproportionately small share. Food proscriptions applied mainly to women, and appeared to have an overall negative effect on women's dietary diversity and intake. The following foods were often served to other household members and not to adult women: soybeans, wild green leafy vegetables, potato pickle, banana, mango, fish, eggplant, cow milk yoghurt, cow milk ghee, buffalo milk, and chili. Women consumed wheat products, pork, chicken, eggs and liquor even less frequently. Some foods, considered difficult for infants to digest, were avoided by nursing mothers. Foods in this category are not in short supply and there is no reason to avoid them apart from food belief systems. Animal products are in high demand and short supply, and preferentially distributed to adult males and small children. Channelling food away from women therefore appears to be due to a combination of food beliefs and low status.

Examining calorie intake, beta-carotene intake, riboflavin intake, and vitamin C intake, adult women scored lower than children and

males for all substances. This raises concern about the nutrient intake of adult women, who have active daily work routines, culturally prescribed dietary restrictions and additional nutritional needs if pregnant or lactating.

Female labour is crucial for the production of men's cash crops. But it is now also vital that women derive a cash income from trading if they are to purchase additional food and other household necessities. Although women's cash income is comparatively smaller than men's, it is often more significant in terms of a family's standard of living. Moreover, women spend their incomes on the family, whereas men tend to spend theirs on themselves. Women may in fact remain free to spend their own income only because men recognize that they are reinvesting it in family needs, and not accumulating capital independently. Male earnings and social activities, particularly the consumption of alcohol, are becoming increasingly detached from family activities and responsibilities, and are often reported by women to be a serious drain on household income and resources. Women's heavier responsibilities, and the difficulties they experience in carrying them out, lead to conflict between their various roles and reduce their limited leisure time. Dietary practices have further health implications since women customarily allocate more and nutritious food to men,

while making do with bulky, low-calorie staples themselves. Food taboos, which most often relate to high-protein foods, apply least often to adult males. Few men seem aware of the potential nutritional deficits of their wives and children.

Behind most food security policies lies the assumption that once a household obtains sufficient food, all its individual members will be adequately nourished. The Indian experience shows that improving a household's access to food does not guarantee that the women in the family will receive sufficient food. Gender bias in nutritional status and food distribution within the family has been recognized only recently, despite an abundance of data on the issue. With the advent of the UN Decade for Women, further research on female nutrition was undertaken, nearly all of which underlined the fact that most development initiatives had either ignored women, failed to recognize their particular problems, or even worsened their situation. Most nutritional surveys in India monitor the status of households rather than that of individuals, using the Consumption Unit which is based on norms rather than actual intake. One Consumption Unit is the recommended daily calorie intake of a male sedentary worker, and all other age-groups, sexes, and activity levels are taken as a proportion of this measure. There is little evidence that Indian women actually receive even this proportion of the family's food resources. Concern

over women's nutritional status is confined to pregnant and lactating women, their nutritional and health status prior to and after these stages receiving little or no attention. These women are defined, along with pre-school age children, as a "vulnerable" group and the traditional recommendation has been to provide supplementary nutrition to offset some of the ill effects of their nutritional status quo. However, this approach leaves the nutritional needs of the vast majority of poor women unaddressed, and provides a partial explanation of the declining female: male sex ratio, higher female infant mortality rates, and high maternal mortality rates.

There is plenty of evidence that the lower status of women in society is among the basic underlying causes of maternal malnutrition and women's poor health.

Lower status of women is well reflected in the fact that many societies prefer boys to girls, offer better education and job opportunities to men, pay women less for the same work, and often see them in less prestigious jobs with very little access to decision-making. In the poor rural areas of developing societies, women have a higher share of illiteracy, overwork, undernutrition as well as loss of traditional support systems and the burden of heading the household due to accelerating male migration.

Women's status defines their position in society. It is both their standing as well as the perception in society as to where they actually belong. Women's status is often characterized through a set of social, political and economic indicators:

1. The group of political indicators consist of: (a) legal entitlements; (b) participation in the political process; and (c) authority through holding offices either via election or by appointment.
2. Indicators of economic position include: (a) participation in labour force; (b) job security; (c) wage rates; and (d) education and specialization.
3. Indicators of social position are: (a) marital relations; (b) maternity benefits; and (c) divorce, child custody and child care.

Historically, poorer women have had to work and have received few societal benefits. Interestingly enough, what is known about women is based on records and thoughts of men. It was only in the 18th century that women began to organize themselves around the issues of their own concerns. Their situation at that time has been described as fragile, domestic and dependent.

In the United States, change of women's status began in the 1920s and have continued ever since. Initially, women gained the right to vote, common access to primary education, and gradually improved

their social and economic position. Over the past two or three decades, women in the industrialized world have gained substantial social, political and economic rights. For instance, rights to equal job opportunity, equal pay, property and credit, as well as expanded educational opportunities, increasing political participation and organization, have been tremendous improvements. Family roles are changing too. For instance, substantial change in age at marriage (22 years in the USA), having the first child as late as 30 years of age, and sharing of men in child care and housework are to be noted.

In summary, women have gained status almost equal to men which, in the opinion of some experts, is not fully secure.

In the third world, attention to women's issues has been a much slower process. The UN Commission on the Status of Women was established in 1948. However, the first worldwide effort to enhance the status of women began with the UN Conference on Women in Mexico in 1975 and followed through with the UN Decade for Women 1975-1985.

Experts such as Margaret Leahy see a connection between the global concern over food and population issues in the sixties and a new level of attention to the women's issues. Actually, two major international conferences on food and population in the early 70s made

it clear that women have a central role in food production and fertility control, and there was an almost sudden awareness as to how little the world knew about women. It also became clear that success in policies and programmes geared to better nutrition, family planning and population control were heavily dependent on enhancing the position of women.

Since then, progress made in enhancing women's position has been reviewed in two major international conferences in Copenhagen (1980) and Nairobi (1985).

Important progress in the last ten years includes the following. First, the state of knowledge and information on the conditions of women in the world have improved dramatically. Second, the role and contribution of women to national development, family life and societal welfare is now much better documented and understood. In other words, the links between women's status and national development are clearer now. Therefore, women and women's advocates can be much more effective in defining women's issues and placing them on the national and international agenda. Third, substantial experience has emerged in numerous countries in dealing with women's issues from a variety of perspectives. Already, good beginnings have been made in many countries, and through persistence and hard work, much more could be achieved.

It has been argued that in the long run, industrialization and sustained national economic growth are the critical preconditions for enhancing the position of women. However, it is no secret that many developing countries have experienced serious difficulties in their efforts for industrialization and economic advancement. Furthermore, there are several serious barriers to women's participation in economic and political spheres.

Illiteracy and poor education lie at the heart of women's lower status. Today 27.7% of men and women are illiterate in the world. Table IX shows the alarming contrasts between the industrialized and developing world as well as those between women and men. Level of illiteracy in the developed world is only 1.7 for men and 2.6 for women. In the developing countries, illiteracy is 16 times higher for men and 20 times higher for women. In the least developed countries in the world, more than half the men and three-quarters of the women are illiterate. In the developing countries, there are almost two illiterate women for each illiterate man. Looking at the regions of the world, the highest illiteracy is found in African and the least in Latin America with Asia being somewhere in between.

In many traditional societies, education is considered as preparation to leave home while women's traditional place is at home.

This logic cuts across several social strata. It explains why more boys are sent to school in several classes, societies and regions of the world. A look at primary school enrollment shows that the female disadvantaged position is likely to remain for the next generation in Africa and Asia.

The primary school enrollment in the developed world is 92/92 for men and women, and in the developing countries it is around 79/66. In Latin America there is no gap between boys and girls and the ratio is 88/88, while in Africa and Asia respective rates are 72/60 and 81/65. Some experts argue that education gaps between men and women widened since boys gained access to the western-modeled education and girls did not. This is particularly true in the Islamic nations. Women's education in all probability is a critical precursor to closing the gender gap, facilitating their political participation and moving them from the periphery to the mainstream of development. Educated women are much more effective in their own welfare as well as that of their family. At the very basic level, illiterate women often find it hard to absorb modern methods of sanitation, management and prevention of disease, nutrition, fertility regulation and pregnancy care. Women with no education are more apt to embrace the traditional status quo and less open to change for better health and family practices.

Furthermore, the prevalent social attitudes towards the role of men and women and sometimes the religious teachings play a strong role in conditioning women's economic and political position. In societies where the appropriate social role for women is perceived to be a wife and mother, then it becomes extremely difficult for them to expand their economic role and social mobility. Under such circumstances, women are primarily responsible for the reproductive process while being denied the right to control it.

The discussion thus far indicates that future positive change in status of women is primarily a matter of education, empowerment through organization and political participation, change of attitudes in society and economic control.

Unfortunately, there is no clear and conclusive analysis as to whether any of these variables function as precursor to the other. However, industrialization, economic growth, combined with education and empowerment of women, could result in better social and economic positions for them.

The clearest indicator of discrimination against Indian women is the skewed sex ratio. There were only 927 females per 1000 males in India (the world average is 990 women per 1000 men), according to

the 1991 Census. Provisional figures for Census 2001 indicate that the trend has been slightly arrested, with the sex ratio at 933 females per 1000 males, with Kerala at 1058 females.

Yet cause for concern remains. The sex ratio of the 0-6 age group has declined sharply from 945 in 1991 to 927 in 2001. One reason for the adverse juvenile sex ratio is the increasing reluctance to have female children. Portable ultrasound machines and sex determination tests have made possible to detect and abort the female foetus. Social neglect of women (and girls) is the other contributing factor.

Poverty, early marriage, malnutrition and lack of health care during pregnancy are the major reasons in both maternal and infant mortality. In rural India almost 60 per cent of girls are married before they are 18. Nearly 60 per cent of married girls bear children before they are 19. Almost one third of all babies are born with low birth weight.

Maternal mortality in India is the second highest in the world, estimated to be between 385-487 per 100,000 live births. Close to 125,000 women die from pregnancy and pregnancy related causes each year. Antenatal services are poor with only 53.8 per cent receiving

tetanus toxoid injections and 46.8 per cent having their blood pressure measured. 80 per cent of women are anaemic. As many as 58 per cent reduce their food intake during pregnancy instead of increasing it. Two-thirds of deliveries still take place at home, with only 43 per cent supervised by health professionals. Only 52 per cent of couples in the reproductive age groups use contraception.

For the country as a whole, nutritional standards are poor with cereal consumption per capita having fallen from 17 kgs per month in 1952 to 13 kgs per month in 1993-94. Calorie intake has also declined. Forty per cent of males and 41 per cent of females suffer chronic energy deficiency. A shocking 50 per cent of [Children fewer than five are malnourished and 70 percent anaemic because of nutrition deficiencies. Anti-people policies alone can explain the paradox of tonnes of grain rotting in FCI godowns while people go hungry.

Poverty and lack of awareness also hinder mothers from giving adequate care for their children. For instance, although diarrhoea is the second largest killer of babies, only 43 per cent of mothers know about ORS and only 26 per cent report ever having used it. Similarly, only one-third of children are fed complementary foods between the ages of six and nine months when breastfeeding should be supplemented. The

second National Family Health Survey suggests that uneducated mothers tend to lose the most infants.

Social restrictions on women's mobility also contribute to lesser healthcare for women and children. For example, 90 per cent of married women in Uttar Pradesh and Jammu and Kashmir and about 30 per cent in Bihar, Madhya Pradesh, Rajasthan, Haryana, West Bengal, Andhra Pradesh and Assam need permission to visit even friends and relatives.

Women's health tends to be viewed narrowly as reproductive health, whereas many factors need to be considered. For instance, communicable diseases are more of a threat to women than pregnancy. Tuberculosis and not pregnancy is the leading cause of death of women in the reproductive age group, followed by burns and suicides.

The privatization of the health sector has increased the burden of the poor. Studies suggest that illness is the second highest cause for rural indebtedness. Government spending on public health fell from 1.26 per cent of GDP in 1989-90 to 1.12 per cent of GDP in 1995-96. Only 50 per cent of villages have any government health facility.

Only 62.3 per cent of Indian households have access to safe water -- 81.4 per cent urban and 55.5 per cent rural households. This

means that women spend a considerable amount of time carrying water from distant wells and other sources, adding to women's burden.

Access to sanitation facilities is a special problem for women and girls, given the social emphasis on privacy and seclusion. Having to go out exposes them to harassment. Women and girls living in urban slums are particularly affected. Public toilets for females are few. Many schools do not have toilets for girls and women teachers. By 1995 only 15.2 per cent of rural people had access to toilets.

In 1951, shortly after Independence, the Census recorded that only 25 per cent of men and 7 per cent of women were literate. By the 1991 Census, female literacy had risen to 39 per cent. Census 2001 provisional figures indicate that 54.16 per cent of women are now able to read and write. Still, 245 million Indian women cannot read or write, comprising the world's largest number of unlettered women.

National averages in literacy conceal wide disparities. For instance, while 95 per cent of women in Mizoram are literate, only 34 per cent of women in Bihar can read and write.

Since the majority of India's unlettered people are female, literacy and education programmes need to focus on girls and women. Yet progressive government programmes like the Mahila Samakhya, that designed a scheme to conscientise and empower rural

women and motivate them to educate themselves, have been distorted in recent years. The District Primary Education Programme focuses on enrolment but not on the retention of girls in schools. In the absence of an enabling and empowering environment, girls are unlikely to stay on in school, say critics of the large World Bank funded programme.

The average Indian female has only 1.2 years of schooling, while the Indian male spends 3.5 years in school. More than 50 per cent girls drop out by the time they are in middle school.

Women's organisations point out that sibling care is a major reason for girls dropping out of school and suggest that creches be attached to schools so that girls are free to attend classes. Midday meals, free books and uniforms, and the provision of toilets are other facilities suggested to bring more girls into the school system, besides more same sex schools and more female teachers.

The women's movement has repeatedly called upon the government to fulfill its pledge to invest 6 per cent of the country's GDP in education. But in fact expenditure on education fell from 3.4 per cent of GDP in 1989-90 to 2.8 per cent in 1995-96. Further, amounts actually made available and real spending falls far short of budgetary provisions.

Most of the work that women do, such as collecting fuel, fodder and water, or growing vegetables, or keeping poultry for domestic consumption, goes unrecorded in the Census counts. Many women and girls who work on family land are not recorded as workers. In 1991 women and girls comprised 22.5 per cent of the official workforce. Data from the National Sample Surveys records higher work participation by women than the Census.

Women constitute 90 per cent of the total marginal workers of the country. Rural women engaged in agriculture form 78 per cent of all women in regular work. They are a third of all workers on the land. The traditional gender division of labour ensures that these women get on average 30 per cent lower wages than men. The total employment of women in organised sector is only 4 per cent.

Although industrial production increased in the 1980s, jobs in factories and establishments or non-household jobs -- stagnated at eight per cent of the workforce. Increasingly, companies tend to rely on outsourcing, using cheap labour.

It is well known that women and children work in huge numbers in bidi-rolling, agarbatti-rolling, bangle making, weaving, brassware, leather, crafts and other industries. Yet, only 3 per cent of these women are recorded as labourers. They are forced to work for pitiable wages

and are denied all social security benefits. A study by SEWA of 14 trades found that 85 per cent of women earned only 50 per cent of the official poverty level income.

Crime against women has been rising with each year. Violence, both outside and within the household, is a grim reality of women's lives. Between 1990 and 1996 crimes against women grew by 56 per cent. Cruelty to wives comprised 28 per cent of all crimes in 1996.

The extent of trafficking in women is unknown. However, one official study admits to 100,000 prostitutes in six metro cities. Of these, 15 per cent are girls below the age of 15. Cross-border trafficking is common.

According to the National Sample Survey Organization figures, one out of ten households is headed by a woman. Women-headed households include widows, deserted and divorced wives and single women. They tend to be among the poorest households in the country. There are indications that the number of such households is rising and that the NSSO figure is an underestimate.

The status of tribal women is in some ways better than that of other women, for instance, female infanticide is lowest among the tribal people. Tribal women work shoulder to shoulder with men and

have a higher status than many caste Hindu women do. Still, violence and oppression is a common occurrence. They are doubly oppressed as part of a community that is among India's most deprived people. Their customary access to the forests has been restricted with the government appropriating forests and forest produce through a series of damaging legislations. Large numbers of tribal people have been displaced from their homes by modern so-called 'development' projects including mines, giant industrial plants, dams and electricity projects as well as defense installations like missile ranges.

Women have equality of status under the country's Constitution. However, many anomalies remain under different laws.

During the 25 years of the women's movement the government has amended several laws that affect women, including laws related to dowry, rape, cruelty, maintenance, prostitution and obscenity. India has ratified international conventions such as the Convention on the Elimination of Discrimination against Women (CEDAW). It has set up family courts in some states and the judiciary has issued a series of progressive judgments in favour of women, including a recent judgement on sexual harassment at the workplace and on child custody.

However, Hindu law still does not give women equal rights in ancestral property. For instance, they cannot be coparceners in ancestral property and have limited rights to inherit it. They cannot ask for division of the property. No law exists to prevent wives from being thrown out of the matrimonial home. Separated, deserted or divorced women face major hurdles in claiming maintenance for themselves and their children.

The government has been singularly reluctant to address the issues of minority women's rights. The constitutional stipulation to chart a Uniform Civil Code has been unsuccessful so far because, by and large, the effort has been to impose Hindu law in the name of a Uniform Code and to ignore even the positive aspects of Personal Laws of other communities.

Although Indian women played a major role in the freedom movement, it did not translate into continued participation in public life in the post-independence era. On the contrary, many women withdrew into their homes, secure in the belief that they had ushered in a democratic republic in which the dreams and aspirations of the mass of people would be achieved.

Representation of women in the state legislatures and in Parliament is low. Women currently comprise 5.9 per cent of Lok

Sabha members. In the 1999 elections a mere 6.5 per cent -of candidates were female.

Women have persistently lobbied for the passing of the 81st Amendment Bill, drafted in 1996, that proposes the reservation of one-third of seats in the Lok Sabha. But political parties have repeatedly sabotaged attempts to have the Bill approved.

However, hope lies in India's huge experiment with grassroots democracy through the *panchayats*. Nearly a million women have entered the *panchayats* and local bodies, thanks to one-third reservation in these bodies through the 73rd and 74th. Amendments of the Constitution. Women head one-third of the *oanchayats* and are gradually learning to use their new prerogatives.

Both research and activism has focussed on the negative fallout of the process of globalisation and liberalisation on women. They have demanded that the investment in the social sector be increased. But a government bent on opening up the economy to foreign investment and free trade has paid no heed to these voices, although India has experienced industrial recession and a period of jobless growth in the past decade. Given the high levels of the population and a large population below age 20, the demand for employment is growing and

joblessness and accompanying frustrations have contributed to violence, frequently expressed as ethnic, caste, class or communal conflicts. Women are the worst sufferers in such conflicts.

Besides raising these economic issues, sections of the women's movement are questioning the oppression of Dalit women. Muslim and Christian women are strongly demanding equal rights.

The war in Kargil has spurred activism for peace. Women were the first to lead a peace delegation to Pakistan in the post-war period, breaking the ice and initiating people-to-people dialogues. Issues of conflict and peace are important, given the tremendous suffering of women in Jammu and Kashmir and in the North East region.

Cross-border trafficking of women and girls is a major problem that remains untackled. Lobbying by women's groups of the South Asian region forced the SAARC countries to include in their Male Declaration of 1997 a paragraph on trafficking and a commitment to sign a regional convention on trafficking. This commitment has yet to be fulfilled.

The Constitution had promised free education for all Indian children up to the age of 14. This promise was never fulfilled. The government is contemplating passing a law to grant children ages 6-14

the right to education. Child rights and women's activists argue that this right is already enshrined in the Constitution and the Right to Education Bill has been designed to absolve the government of its responsibility towards those under six years of age.

The National Commission for Women has made a series of recommendations for legal reform and other measures that deserve consideration but have so far been ignored by the government. Last year the Indian government reported to a UN Committee on the status of implementation of the Convention on the Elimination of Discrimination of Women and was congratulated for bringing women into *panchayats*, but criticised on other counts including denial of rights to minority women.

Activists have drafted a Bill on Domestic Violence after national consultations with women's organisations and lobbied for its passage. An official version is likely to be introduced in Parliament shortly.

The government has declared 2001 as the Year of Women's Empowerment or Swashakti. A policy for the Empowerment of Women was drafted in 1996 but has been in cold storage since then. It has recently, in March 2001, been passed by the Cabinet but has still to be made public. Even the Parliamentary Committee on Women's Empowerment has been denied the document.

A pregnancy related death is the death of a women while pregnant or with in 42 day the cause of death. The international classification of disease has recommended the maternal death resulting from obstetric complication of the pregnant state interventions, omission, incorrect treatment of from chain of event resulting from previous existing disease or disease that development during pregnancy and which was not due to direct obstetric cause but which was aggregative by physiologic effect of pregnancy.

A woman's socio-cultural situation and her health are very closely inter-related. Earlier there was a tendency to view health purely in bio-medical terms, but there is an increasing awareness that a woman's health is a product of the complex social, economic and cultural (perhaps even political) circumstances in which she lives. While these factors affect the health of all individuals, they affect women's health more. Some of the different socio-cultural factors affecting women's health are as follows - financial status, education, religion, cultural mores, patriarchy, mobility and so on. Interestingly, socio-cultural conditions are not just contributing factors but also consequences of women's health situation. A small example will illustrate this situation. On the one hand son preference is one of the important reasons behind a woman undergoing repeated pregnancies and sex-selective abortions. On the other hand the inability to bear

sons, leads to a consequence where women have to face social alienation and even desertion.

With above view, a door to door research investigation on social & psychological factors leading to anaemia among rural women was carried out in rural population of district Jhansi.

Various researcher have been done to highlight the problems of women but very few attempts have been made to study the overall perspective of women is social psychological factors of anaemia.

This study has been attempted for the first time in Jhansi. District the factors leading anaemia of rural women in relation to various health problem which are present day part of the rural women.

Anaemia is very common health problem among rural women and hence the importance of this study increased automatically. First of all it has been found that in Bundelkhand region no such study has been attempted and data available regarding anaemia among rural women are scanty and rough estimate suggest that about 70% of the women in rural area of Bundelkhand suffers from anaemia. Therefore to get information regarding this problem will be helpful, this study shall be useful to planner, health administrator, health personnel, general peoples and research workers those who want to conduct similar studies. The valuable information of this study will also assist and provide new direction to those people who are working in the field of health.

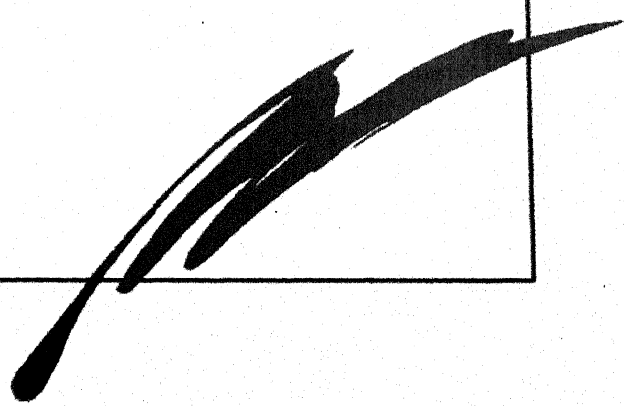
OBJECTIVE OF STUDY :

- To study the socio-economic & demographic characteristics of women suffering from anaemia.
- To identify the main health problems among the women associated with anaemia.
- To assess social, economic, psychological and cultural factors leading anaemia among women
- To assess nutritional diet of women.
- To evaluate the MCH(maternal and child health) services provided to women.
- To assess the health schemes initiated to improve the health status of women,
- To suggest measures for the improvement in health status of women in a studied village.



Chapter-2

Review of Literature



*Chapter-2***REVIEW OF LITERATURE**

Researcher have reviewed & gone through the books, literatures, journals, reports & thesis of prominent sociologist & learned researchers to summarize & simplify the complicity of the selected research subject.

Chaoudhry and Manglik (1938)

Observed, in 2,400 antinatal women from Agra (U.P.) that only 5.0% them were anaemia Hb, level below 7.25% gm %.

Ganguli (1954),

He reported in increase in the prevalence rate of anaemia with the advancement of age. The mean haemoglobin level was also low in higher age group being 69.8% in above 20 years and 72.2% in below 20 years ago group.

Venkatachalam (1962)

Observed that amongst 198 women examined in the third trimested of pregnancy, 56% were anaemic.

Hunt Venessa

Observed that 35 studies met the inclusion criteria on the uptake & response to VCT of which 21 were specific to pregnancy. There are

many factors which affects the uptake of VCT services including knowledge and perception of HIV, MTCT & VCT for stigma and demographic factors. Once testing has been undertaken women have to take decision and several areas which are discussed in counseling; returning for the disclosing the test result & contraception & infant feeding practices.

Gajwani *et al* (1969)

Opined that variations in the prevalence of anaemia, between countries, and within different regions of the same country, are chiefly due to the differences in socio-economic status, custom, nutritional status and cultures of the people. However, in part it may also be due to the differences in the criteria adopted for labeling anaemia.

Subramaniam & Fornades (1970)

Observed the distribution of anaemic mothers as 93.75% in microcytic hypochromic group, 3.12 % in demographic group and 2.34% megaloblastic group, Refractory anaemia was found in 0.79% cases.

W.H.O (1970)

Lack of iron in diet and increased iron demands during pregnancy are the major causes of iron deficiency among rural women. However the relatively recent detection of folic acid deficiency in

pregnant women as a definite entity has positively led to an improvement in the management and diagnosis of anaemia.

Since the 1970s,

The increase in scientific documentation on women's issues has also been reflected in the nutrition literature. From a narrow focus on women's biological role and needs, there has been a shift towards a more expanded perspective on women and nutrition to include the economic and social aspects of their life situation.

Metha (1971)

Reported that out of 143% anaemic cases, 67% had inadequate folate in their diet.

Yusul ji et al (1973)

Observed, in his study, that majority of anaemic rural women were normal on physical examination. Among those who had sign of anaemia, glossitis was found in 19% and stomatitis in 7 % cases.

Hize, Stephane (1977).

Observed that the prevalence of anaemia at 32-36 wk gestation (Hb<110g/L) was 53.3% at day 3 post partum (Hb< 100g/L) 32.9% and at day 7 post partum 27.2% there was a significant association between

maternal anaemia & lower haemoglobin concentration above 105 g/L infant abnormalities were not presented among mothers having a haemoglobin concentration above 115/g/L.

Protein Advisory Group of the United Nations system in 1977.

In this report, women's roles in food production, food handling, and nutrition were analysed on the basis of a review of documentation from the social sciences as well as nutrition and medical research.

Rural community of Ludhiana revealed

A study conducted in 30 out of 53 womens to have a haemoglobin level less than 10gm.

Kumari, (1989)

Physical and psychological oppression including abuse, threats and slaps, demand of more money and gifts, which had devastating effect on mental as well as physical health of women.

I.C.M.R., (1990).

Showed that only 10 per cent of the studied worries were consuming a balanced diet. Majority of the women were suffering from anaemia and complained of backache, head ache and pain in the body. A balanced diet ensures nutritional adequacy, increases food

acceptability, adds variety and also increases the resistance to various diseases.

Census (1991)

A critical element of the health care system is the health of women in the child bearing age and children under five. As per the 56% of the population in India fall under this category. Anaemia, chronic undernutrition and complications during pregnancy and child birth are the orders of priority for tackling maternal health.

As intestinal mucosa remains tuned to the body requirements of iron, the findings reported here have important implications with respect to the treatment of iron deficiency anaemia. The increased expression of transferrin receptor at the site of iron absorption in deficient conditions can functionally increase iron absorption. This is achievable only when saturating amounts of iron are present in the intestinal lumen. However, when therapeutic doses of iron are given the concentration of mucosal ferritin increases and blocks the further entry of iron into the mucosa. In this context, administration of iron intermittently rather than daily is a useful strategy.

The studies show that when iron deficient rats are repleted with a high dose of iron along with the antioxidant vitamins C and E, almost all the intestinal oxidative stress is reduced.

Recent Studies at the NIN, Hyderabad

For the past 5 years studies have been carried out at the NIN, Hyderabad to answer some of the concerns regarding iron absorption and the behaviour of intestine to large supplements of iron.

Sugunar (1995).

The pain, anguish, oppression, and desertion experienced by women in their marital relations shatter their dreams and often women tend to be silent due to patriarchal notions of the privacy of family.

Doyal (1995).

Identifying physical and psychological health as basic human needs of man and woman, in a study analyzing the socio-economic, cultural and, political constraints which limits women from meeting their health needs, argues that gender-specific inequities of unequal burdens of domestic labour, relative powerlessness even in determining women's own sexuality, unequal distribution of household resources, discrimination in wage work, political constraints and violence are barriers, which hinder the well-being of women.

Zive *et. al* (1996)

Reported that deficient intakes of essential nutrients such as calcium, iron, magnesium, zinc, folate, vitamin A, vitamin B5, vitamin

C, were found more in large proportion of young women than young men. A faulty diet can certainly be a source of stress and this leads to the formation of poor dietary habits. Women with deficiencies of folic acid and other B-vitamins are at an increased risk of cardio-vascular diseases.

S.M. Ziauddin Hyder¹ (1996)

Objective: Determine the magnitude of social stratification of anaemia among the non-pregnant women in a rural area of Bangladesh. Current prevention and control programmes for anaemia have been limited in their effectiveness. A contributing factor for this limited effectiveness could be that there is a social stratification of anaemia among the women and that the programmes may not reach the strata of women with the highest prevalence of anaemia.

Methodology: The study was carried out in 12 villages of Fulbaria thana of Mymensingh district. One hundred seventy-nine married healthy women aged 15-45 years were selected. Information on indicators of socioeconomic situation and haemoglobin concentration was collected through household visit. The socioeconomic indicators included household economic status, schooling of women, and land ownership. A socioeconomic score was developed where these three

indicators were combined. Haemoglobin concentration was assessed on a fingerprick blood sample using a portable photometer and disposable cuvettes. Haemoglobin concentrations were categorized into normal ($120+ \text{ g/L}$ of haemoglobin), mild ($100-<120 \text{ g/L}$), moderate ($70-<100 \text{ g/L}$), and severe ($<70 \text{ g/L}$).

Results: The overall prevalence of anaemia among the women was 73%. The prevalence of severe, moderate and mild anaemia was 1%, 21%, and 51% respectively. All the three indicators of socioeconomic situation were found to be associated with the prevalence of anaemia. Women without formal schooling had a prevalence of 78% compared to 68% for women with schooling ($p<0.05$). Women who lived in the households with less than 50 decimals of land had a prevalence of 79% compared to 63% if they had more land ($p<0.05$). Finally, women who perceived their economic situation as deficit had the prevalence of 83% compared to 68% among those who perceived it as non-deficit ($p<0.05$). The combined socioeconomic score was associated with anaemia in a stepwise manner, and the prevalence of anaemia increased with each additional negative socioeconomic indicators. Women exposed to all three negative aspects had a prevalence of 86% compared to 58% among those not exposed to any socioeconomic risk factors.

Conclusion: Anaemia is a highly-prevalent health problem among women in rural Bangladesh. Although most women are affected, those from poor socioeconomic strata have the highest prevalence of anaemia. To improve the effectiveness of anaemia prevention and control programmes, it may prove to be of value to ensure that the programme coverage of women of the poorest socioeconomic strata is sufficiently high.

Stoney, (1999).

Keeping this in view, the present study has been undertaken with the following objectives. Diet and nutrition are important factors in the promotion and maintenance of good health throughout the life cycle. Income, prices, individual preferences and beliefs, cultural traditions, as well as geographical, environmental, social and economic factors all interact in a complex manner to shape dietary consumption patterns and affect the morbidity and clinical status of women. A normal balanced diet must include daily foods from the various food groups in sufficient amounts to meet the needs of an individual and to increase immunity. The present study is undertaken to study the Health and Well-being of Rural women. For the purpose of study, 75 women between the age-group 25-45 years who were moderate workers, were

selected from rural areas of district Yamunanagar, (Haryana). The mean daily intake of nutrients was calculated by using the Food Composition Tables and was compared with the Recommended Dietary Allowances for adult women.

The National Family Health Survey 1998/99 (NFHS-2)

Provides nationally representative cross-sectional survey data on women's hemoglobin status, body weight, diet, social, demographic and other household and individual level factors. Ordered logit regression analyses were applied to identify socio-economic, regional and demographic determinants of anaemia.

Dr. Kedar Prasad Baral :

Objective : To review prevalence and distribution of anemia and public health significance of the problem in Nepal

Results: There has not been adequate study in relation to consequences of iron deficiency anemia in health. Iron deficiency anemia is moderate to high magnitude of public health problem in Nepal. Although, many of the studies reviewed were not large enough to represent more than 80 percent of rural inhabitants of Nepal, there are sufficient evidences that it has not been improving as compared to other health problem like diarrheal diseases. In children, none of the studies showed that prevalence below 20% and representative studied

showed much higher prevalence of up to 90%. Among women of reproductive age the lowest prevalence was 66% and among pregnant mothers a bit higher is found. The least studied group is adolescents and the lowest prevalence is 42% among them.

Conclusion:

Considering the magnitude of anemia, there should be a multi-prong community-based programme for the prevention and control of anemia. Strategies should include improvement in dietary intake of iron, food fortification, and integration with other development programs. Oral iron supplementation remains the primary approaches for anemia prevention and treatment for short and medium term strategy. In Nepal context, strategies to reach large sections of the women, children, and adolescent population are only possible through community based approach. found that there was a need to formalize clinic-based PNC care to ensure the provision of basic interventions aimed at preventing postpartum problems and/or detecting and responding to them early, with a view to reducing maternal and newborn mortality and morbidity.

Kakuma and Dadaab (2000)

However, despite the deficiencies found in the safe motherhood services in the camps at Kakuma and Dadaab, mortality rates were again found to be low. In 2000 there were four maternal deaths

reported in Kakuma camp (maternal mortality ratio 216 per 100,000 live births) and twenty-two maternal deaths in the Dadaab camps (maternal mortality ratio 460 per 100,000 live births); some of these deaths were caused by either malaria and/or anaemia.

Angola (2001)

The recommendations made at the conclusion of the assessment, relevant to safe motherhood (and other aspects of reproductive health care), included the reconstruction and resupply of health facilities, improved referral procedures, more ambulances/adequate transport options, qualified/trained professionals, and essential drugs.

Zambia (2001)

Assessment of reproductive health for refugees in Zambia found that safe motherhood services were better for refugees than for the local population. Antenatal care for refugee women was found to be satisfactory, although there was some variation between camps/locations; for example, syphilis testing appeared to be available at some camps/ locations but not at others.

Hunt. V (2002).

A literature review on the uptake and response by pregnant women to voluntary counselling and testing to reduce mother-to-child transmission of HIV in resource-poor countries.

This research investigates the prevalence and determinants of anemia among women in Andhra Pradesh. We examined differences in anemia related to social class, urban/rural location and nutrition status body mass index (BMI). We hypothesized that rural women would have higher prevalence of anemia compared to urban women, particularly among the lower income groups, and that women with low body mass index (BMI; $<18.5 \text{ kg/m}^2$) would have a higher risk compared to normal or overweight women.

Dhaka 1000 Bangladesh

Although the data on food intake among women is rather limited several studies have shown that calorie intake among young women in Africa was only 50-70% of their recommended allowance. Similar data on food intake among poor women in India, Philippines, and Gambia have shown that women's calorie intake was no more than 60-65% of their needs. Interestingly enough, food intake among women in Mexico and Korea have been reported as being within the adequate range. Clearly, there is need for better data in this area. However, plenty of corroborating evidence from sources such as household budget surveys and food and nutrition surveys point to the fact that a

chronically low level of food intake exists among low income households, and women and young children are often at a relatively higher risk of food deprivation. As a matter of fact, several of the indicators of poor health among women, particularly low weight gain during pregnancy and widespread nutritional deficiencies, are partly explained by poor diet and chronic undernutrition.

Zeba Mahmud, *et al.*, (2005)

Objective: Study the beliefs and practices associated with diet during pregnancy to design appropriate educational strategies and to promote appropriate behavioural change.

Methodology: About 300 pregnant women of Muktagacha thana of Mymensingh district were selected for the study. A questionnaire was used for interviewing the pregnant women to obtain information regarding age at the time of pregnancy, parity, breast-feeding practices, antenatal care, taboos about food, household food habits, and food distribution. Twenty-four-hour dietary recall was used for obtaining information on daily dietary practices of the women.

Results: The mean age and parity of the women were 22 ± 2 years and 3 respectively. The 24-hour food recall data reflected that there was very little variety in the diet, with rice being the primary

component. Only 20% of the women had 3 or more serving of animal protein. Ninety-four percent reported having no yellow vegetables, 59% no fruit, and 65% no oil in their daily diets. Furthermore, 96% of the women were the last people to take food in the house. During pregnancy, 34% of the women were still breast-feeding their last child, even in their 3rd trimester. Of those who did not breastfeed, only 6% had stopped due to their pregnancy. Although only 3% of the women practised taboos about food, they avoided protein and calorie-rich foods, such as egg, hilsha, and mrigal fish. Conversely, 30% reported that the custom of consuming food, such as egg, milk, and green vegetables, was followed in their households. They mentioned a preference for dry cereals. An increased dietary intake during pregnancy, in terms of quantity, was reported by 65%, while 39% reported lower intakes.

Conclusion: To combat malnutrition, intersectoral programmes targeted toward poverty alleviation need to be undertaken. In addition, the whole family needs to be educated on the nutritional needs of pregnant women.

Houston AM *et al.*, (2006)

Purpose: There is a lack of current information concerning the knowledge and attitudes of urban adolescents regarding menstruation.

The purpose of this research was to determine: (1) The prevalence of dysmenorrhea, premenstrual symptoms and other menstrual disorders among adolescents who receive their health care at an urban adolescent health center; (2) The attitudes and expectations adolescents have relating to their menstrual period; and (3) The relationship between teens' attitudes and expectations regarding menses and actual menstrual-related morbidities such as school absenteeism.

Methods: A 35-item, survey was administered to postmenarcheal adolescents ages 12-21 years. Descriptive analysis of the prevalence of the menstrual disorders was completed. Chi-square testing was used to compare the prevalence of menstrual-related morbidities with the level of adolescents' expectations regarding menstruation.

RESULTS: 91.5% of the respondents were African-American. Premenstrual syndrome (PMS) was the most prevalent reported menstrual disorder (84.3%) followed by dysmenorrhea (65%), abnormal cycle lengths (13.2%), and excessive uterine bleeding (8.6%). Only 2% of teens report receiving information about menstruation from their health care provider. Negative expectations regarding menstruation were associated with higher rates of school

absenteeism and missed activities ($P=0.0790$ and $P=0.0297$ respectively).

CONCLUSIONS: PMS and dysmenorrhea are prevalent medical disorders among urban adolescents. Morbidities, including school absenteeism, are higher among those with negative period expectations. Since only 2% of teens received information regarding menstruation from their health care provider. It is imperative that health care providers increase their anticipatory guidance regarding normal menstruation. This may aid in the prompt diagnosis and treatment of menstrual disorders, and decrease their associated morbidities.

Choudhary A. *et al.*, (2006).

A community-based, cross-sectional study was conducted to determine the prevalence of anaemia among unmarried, adolescent south Indian girls in an urban slum setting. A total of 100 apparently healthy girls between the ages of 11 and 18 years were recruited. Their socioeconomic, dietary and anthropometric information was collected, and blood haemoglobin (Hb) was estimated. The prevalence of anaemia ($Hb < 12$ g%) was 29%. Most had mild anaemia; severe anaemia was not seen. Two-thirds of those with anaemia had low

serum ferritin (<12 microg/L). Significant associations were observed between anaemia and low socioeconomic status, religion and reporting infrequent/non-consumption of meat (heme iron). Only meat consumption was related to haemoglobin by multiple regression analysis. Anaemia is a common problem among adolescent girls in this setting, though severe anaemia is rare. There is a need to improve their haemoglobin status through dietary modification along with preventive supplementation and nutrition education.

Ramphal *et al.*, (2006)

Purpose of review: Obstetric fistula has a devastating impact on the lives of women in poor countries. Currently, there is an international campaign by the World Health Organisation, United Nations Population Fund and other bodies to address this problem. This article reviews recent literature and highlights the paucity of evidence-based data.

Recent findings: Articles on the pathophysiology, co-morbidities and sequelae including physical injury to 'multiorgan systems' and social consequences associated with obstetric fistula, are discussed. In particular, the devastating social, economic and psychological effects on the health and well-being, reintegration and

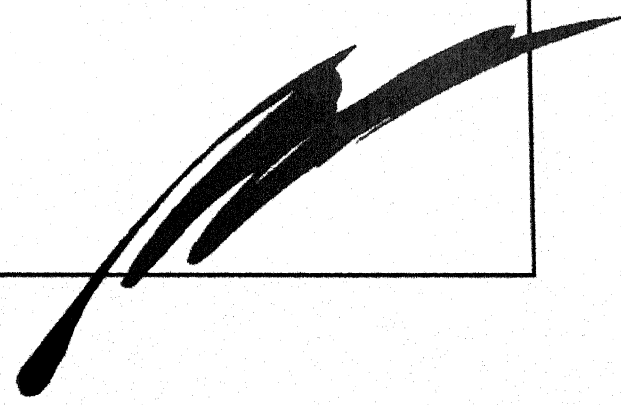
rehabilitation are addressed. There is a need for prevalence and incidence studies to measure the extent of this problem. The creation of well-equipped fistula centres with multidisciplinary teams to evaluate patients should be the aim. Expert surgeons and optimal databases

Researcher has also reviewed many other descriptive reports, thesis & literatures relation to various social & Psychological factors leading to anaemia among rural women in Jhansi.



Chapter-3

Research Methodology



*Chapter-3***RESEARCH METHODOLOGY**

Present study entitled "A Study of Social and Psychological Factors Leading Anaemia among rural women in Jhansi District" is a interdisciplinary research. It was considered necessary for achieving objectivity because study through one particular discipline may be highly based and dogmatic in approach. The researcher may deliberately or inadvertently try to project his own theories into the phenomena to find a possible explanation rather than making the objective study of the source.

Interdisciplinary approach brings a person out of particular discipline and take a more comprehensive view of things. He sees what others have to say about the problem and this helps the researcher to modify his or her views. The Researcher has carried out whole research work consulting occasionally medical expert particularly Head of the Deptt. of Gynaecology of M.L.B. Medical College Jhansi.

In every society one is not entirely different from each other. In the present study homogenous group of women was selected to draw

conclusion. Social sciences have many common boundaries. Socio-Psychological research come in the categories of quasi social research. Data of the present study have been made available from various sources viz documentary and field research. In the present research reliable social sciences research methods and techniques have been used necessary for this kind of research.

Universe:

Universe of the study was selected on the following consideration.

A-Universe was situated 8 km away from Jhansi city.

B-Area was easily approachable.

C-It represented the essential attribute of the population.

The universe of study was village Gumnawara a village of Jhansi District approximately 8 km. away from Jhansi city Medical college was situated 2 km. away from the village and many private Medical Practitioners were practicing in the village.

Village consisted of 300 families according to survey conducted by Deptt. of Obstt and Gyneacology of the Medical college Jhansi.

Research Design –

Research Design represents a compromise dictated by the many practical considerations that go into social research. Research Design is the logical and systematic planning and directing a piece of research. Present study is exploratory study to get experience in formulation of hypotheses for any definite investigation. Purpose of such research to explore the knowledge about the area. This type of research aims at to explore the new area of social realities.

Sampling Method:

Out of 2000 families in the village. 300 families were selected identified as risk families shown in the family survey conducted by Deptt. of Obstt and Gynae Medical College Jhansi. Among 300 risk families one lady of reproductive age group was chosen from each family for the purpose of study using stratified random sampling.

Sample Size :

Total sample size was of 300 respondents.

Instrument used :

A well structured and well designed interview schedule was used as an instrument for collection of data. The respondents were asked to express their opinions freely and frankly assuring them that whatever replies they gave would be kept strictly confidential. A high accuracy level was maintained some time observation techniques was also utilized to cover some data.

Interview techniques :

Selected respondents will be interviewed to get the correct information regarding the study. Researcher will interview personally by this technique reliable information shall be gathered from the respondent in this study by making interpersonal relationship with the women data will be collection.

Primary data :

Primary data is that data which had been collected directly from the respondents, primary data had been collected from the field through interview schedule.

Secondary data :

In secondary data various books, literature, journal, magazines reports and other similar studies were referred a parts from interview schedule secondary data was used relevant to the topic.

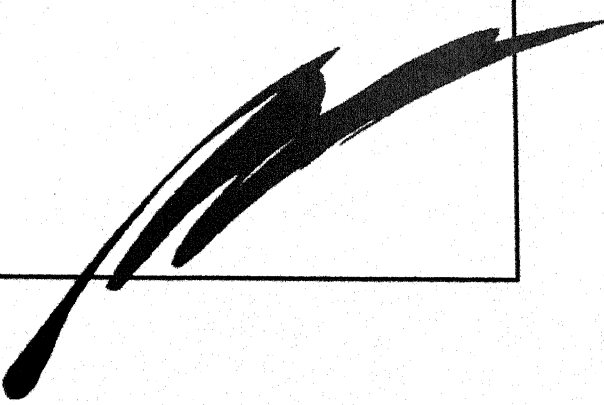
Statistical techniques :

The statistical techniques like percentage, means & frequency table were used in order to get the conclusion.



Chapter-4

Socio-Economic Profile of the Rural Women



Chapter-4

**SOCIO-ECONOMIC PROFILE OF THE
RURAL WOMEN**

Among the towns of North India, Jhansi occupies a special place in India's history especially in the lore of its freedom struggle. It is associated with the illustrious and legendary figure of Maharani Laxmi Bai who fought valiantly against the British in 1857 uprising and made a glorious place for herself in the annals of country's war of Independence.

Under the British, Jhansi developed as an administrative railway and Military centre. It is the administrative seat of the commissioner of Jhansi Division. It is a major railway junction on the North South main trunk route.

The village 'Gumnawara' was very nearest to Jhansi city. It was approximately 8 km away from Jhansi city. In village no satisfactory health services were available at the door step of the people. However 2 km away from the village Medical college was situated.

The present study focuses on "social and psychological factors leading to anaemia among the rural women". In the present chapter the socio-economic status of the rural women have been discussed.

The study focuses on rural women and their social status as a measure of social progress. The transition to a market economy has created new problems for a woman. Macro and Micro economy policies have not always taken into account their interests. Unemployment and poverty have become the norm.

Jobless and poverty affect urban women too. However stagnating rural areas deserve special attention. Rural women face formidable barriers created by their family status, socio-economic hardship and male dominance over women inside and outside the family.

Female poverty is widespread though its incidence varies from region to region. Poverty is particularly acute among rural women, many of whom have less earnings than the minimum subsistence level. Rural areas suffer from deteriorating supplies of natural gas, drinking water and electricity.

Many surveys indicate In Bundelkhand that around 90% of rural families live below the poverty line and are forced to sell their belongings or borrow money. Gender inequality in sharing economic power is another factor accentuating female poverty. Prevailing micro-economic policies acquire rethinking as they emphasized the formal economy to the virtual exclusive of other sectors restrained initiatives taken by women did not distinguish between problems of men and women.

Gender analysis of political platforms and socio-economic programmers is an important tool to formulate a poverty alleviation strategy.

The home economy reflects the status of country. As society gets more structured solutions are found for the demographic, environmental, social, economic, political attitudinal and household problems, educational levels socio-economic problems are especially affecting women who are the sole breadwinner in the family.

The economic transition has directly affected women's status in society, in the past, women's status in society and economy depended on rules defined by the state.

All the anthropometric data showed that women of low socio-economic group had a poor growth status, highlights the fact that women's particularly are anaemic who are below poverty line. Anaemia reflects not only inadequacy of health care services for mothers but also a low standard of living and socio-economic status of the community.

If one is to identify one strategy that would change, the tide of maternal deaths, it would be female literacy and socio-economic status of women. Poverty and lack of awareness also hinder mothers.

Social restrictions of women's morbidity also contribute to lesser healthcare for women and children. For example , 90% of married women in Uttar Pradesh and Jammu and Kashmir and about 30% in Bihar , Madhya Pradesh , Rajasthan , Haryana , West Bengal , Andhra Pradesh and Assam need permission to visit even friends and relatives.

The status of rural women is in some ways better than that of urban women, for instance, female infanticide is lowest among the rural people. Anaemia is very common health problem among rural women and suggests that about 70% of the rural women suffer from anaemia.

Though anaemia is more prevalent among women belonging to lower socio-economic strata of society, it is not uncommon among the well-to-do sections of society. Female literacy and maternal mortality are intertwined in an inverse relationship.

Social factors of anaemia among the rural women are child birth , parity , too close pregnancy , family size , malnutrition , poverty , illiteracy , ignorance & prejudices ,lack of maternal services , shortage of health manpower , delivery by untrained dais , poor environmental sanitation , poor communication & transport facility , social customs etc.

Poverty and early marriage, malnutrition and lack of health care during pregnancy are the major reasons in both maternal and infant mortality. In rural area of Bundelkhand almost 60% of girls are married before they are 18 years. Nearly 60% of married girls bear children before they are 19. Almost one third of all babies are born with low birth weight.

Surveys in different parts of Bundelkhand have revealed that about 50-60% women belonging to lower socio-economic groups are anaemic in the last trimester of pregnancy.

The same set of social factors that affects fertility also responsible for prevalence of anaemia. In societies where the status of women is low. Women face both covert and overt discrimination in the distribution of food within the family. Even in many well-to-do Indian families, the women eat only after the men folk have finished their meals. Thus the use of iron and folic acid tablets is only a short term intervention. Any long term strategy should involve social and educational interventions.

The refusal of Government to reform laws affecting the social and economic states of rural women often results in violence against women. In many societies, women are defined solely by their reproductive function, so was the case in the study area.

Economic and social factors that continue to ensure women's economic dependence on men often result in violence against women. A major factor of anaemia among rural women is their low economic and social status in relation to men and their dependence on men to provided protection and the means of survival.

The low economic status has serious consequences for the social legal status of women. In addition, women's low economic status allows poor practices in the family that result poor health of women.

Low economic and social status has serious consequences for legal position of women. Law in many countries ensures that women remain in an economic dependent situation. Society and Government view men as the representative and heads of household.

Low income is very important factor for women health because low income influence women's diet, poor diet of women during the women's delivery period. So the women become anaemic due to lack of balanced diet. The poverty in India is situated mainly in the rural areas so the women's of rural area are anaemic. So the women of study area are no exception. Some social stigma is very important factor which also create the condition in which women's become anaemic.

Present study aims at to identify the various socio-economic factors which cause anaemia among rural women. In the present study various factors have been discussed to ascertain the condition of anaemia among the rural women.

Table-4.1

Showing age wise distribution of the respondents

S.No.	Age	No. of respondents	Percentage
1	18-30	141	47%
2	31-40	99	33%
3	41-50	40	13%
4	50 & above	20	7%
	Total	300	100%

Above table shows that maximum no. of respondents i.e. 47% belonged to the age group of 18-30 years and 7% of the respondents belonged in the age group of 50 & above. Majority thus constituted of younger age group which is the major reproductive period among rural women of the area under study.

Table-4.2

Showing the educational status of the respondents

S.No.	Educational status	No. of respondents	Percentage
1	Illiterate	141	45%
2	Literate	55	18%
3	Primary	30	10%
4	High School	10	4%
5	Intermediate	32	11%
6	Graduate	19	6%
7	Other	18	6%
	Total	300	100%

Above table indicates that out of total respondents majority 45% were illiterate while 18% were literate , 11% were intermediate , 10% were primary and 6% respondents were graduates and above. This table shows that majority constituted of illiterate women in the area under study.

Table- 4.3

Showing caste wise distribution of the respondents

S. No.	Caste	No. of respondents	Percentage
1	General	46	15%
2	Back-ward	147	49%
3	Dalit	78	26%
4	Other	29	10%
	Total	300	100%

The above table states 49% of the respondents were from backward classes while 26% from Dalits, 15% were belonging to general caste and 10% were from other categories. Thus area was mainly constituted of Backward and Dalit Women.

Table- 4.4

Showing religion wise distribution of the respondents

S. No.	Religion	No. of respondents	Percentage
1	Hindu	291	97%
2	Muslims	9	3%
3	Sikhs	00	-
4	Christians	00	-
5	Other	00	-
	Total	300	100%

Above table is indicative of the fact that 97% respondents were Hindus and 3% belonged to Muslims. The majority were consisting of Hindus.

Table – 4.5

Showing occupation of the husband

S. No.	Occupation of the husband	No. of respondents	Percentage
1	Agriculture	66	22%
2	Labour	46	16%
3	Business	127	40%
4	Government Service	44	15%
5	Private Service	17	7%
	Total	300	100%

Above table shows that 40% husband of the respondents were from business, 22% were from agriculture, 16% were from labour class, 15% from government service and 7% were engaged in private service. Thus majority was from agriculture families.

Table:- 4.6

Showing occupation of the respondents.

S.N.	Occupation	No. of respondents	Percentage
1.	House wife	277	93%
2.	Agriculture	1	-
3.	Labour	17	6%
4.	Govt. Service	4	1%
5.	Private Service	2	
	Total	300	100%

Above table throws light that 93% of the respondents were housewives and 6% were from labour class and 1% respondents were from government service.

Table:- 4.7**Showing no. of family members**

S.N.	No. of family members	No. of respondents	Percentage
1.	3	7	1%
2.	4	49	17%
3.	5	134	45%
4.	More than 5	110	37%
	Total	300	100%

From above table it can be seen that majority i.e. 45% had 5 family members while 37% had more than 5 family members followed by 17% families had 4 family members, which reflects that majority was having larger families.

Table:- 4. 8

Showing monthly income of the respondents.

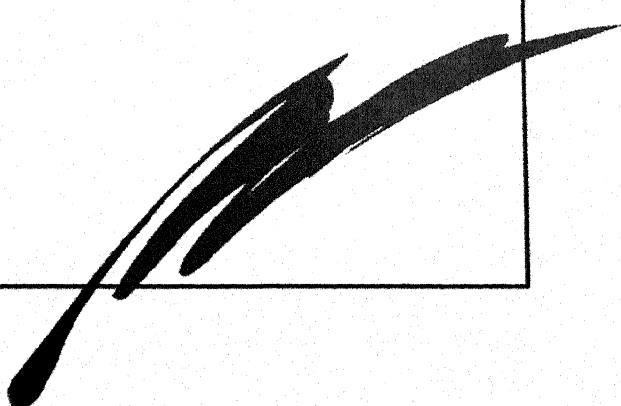
S.N.	Income	No. of respondents	Percentage
1.	500-1500	36	12%
2.	15001-3000	88	29%
3.	3001-4500	90	30%
4.	More than 45	86	29%
	Total	300	100%

Above table throws light that majority of the respondents i.e. 30% were having income between Rs. 3000-4500 followed by 29% were having income more than Rs. 4500pm and 12% were in income group of Rs. 500-1500, which shows Poor Socio-economic status.



Chapter-5

Major Health Problems & Nutritional Status



*Chapter-5***MAJOR HEALTH PROBLEMS &
NUTRITIONAL STATUS**

In this chapter an attempt shall be made to study the major health problems of the rural women and their nutritional diets.

Anaemia is very major health problem among rural women. Anaemic in rural women. According to W.H.O. sponsored studies (WHO, 1968) indicated that prevalence of anaemia in rural women in different parts of world ranges from 21% to 80% the highest being in India.

A WHO Expert Group proposed that "anaemia of deficiency should be considered to exist" When hemoglobin is below the levels.

The term anaemia has been defined as diminution in the oxygen carrying capacity of blood or in other words, diminution below normal in the total circulating hemoglobin mass. The hemoglobin concentration is accepted as one of the indicators for the qualitative and quantitative assessment of anaemia in general.

The end of iron deficiency is nutrition anaemia which is not disease entity. It is rather syndrome caused by malnutrition in its widest sense.

Besides anaemia, there may be other functional disturbance such as impaired cells-mediated immunity, reduced resistance to infection increased morbidity and mortality and diminished work performance.

Due to Anaemia women have suffered many other problems because they have no such more capacity to fight with others diseases. Generally women have suffered from malaria, typhoid, tuberculosis, irritating behavior, breathing problems, giddiness feeling, weight loss, yellow nails, working capacity of the women is also very low. Women have sufferd from anaemia. Because the main cause of anaemia in women is high bleeding during delivery and high bleeding during mentrusation. So from this reasons the women become very week and her immunization system worked very weekly and women suffers from anaemia.

Iron deficiency and iron deficiency anaemia are not synonymous. In fact anaemia is a very late manifestation of iron deficiency. The individual is born with minimal or nil iron stores. The body starts storing iron after birth. In India and in many developing countries, women are not able to build their iron stares because of poor nutrition, repeated infections, menstrual blood loss and repeated pregnancies.

In rural women severe anaemia is important risk factors in pregnancy. Reports from India indicated that 16% of all maternal deaths are attributable to anaemia. Maternal anaemia also contributes to an increase in perinatal mortality low birth weight and foetus wastage.

In the past, several studies have shown that iron deficiencies anaemia often leads to irreversible impairment of the women. Generally the rural women are suffering from anaemia due to imbalance diet and lack of awareness.

Anaemia is considered as a condition of reduction in the concentration of hemoglobin in the peripheral blood the normal for the age and sex.

Dietary inadequacy is the main cause for the high prevalence of vitamins deficiency and iron deficiency, characterized by poor iodine deficiency of iodine in food and water.

Diet and nutrition are important factor in the promotion and maintenance of good health throughout the cycle , income , prices , individual preferences and beliefs , cultural tradition as well as geographical , environmental , social and economic factors all interact in a complex manner to shape dietary consumption pattern and affect

the morbidity and clinical status of women. A normal balance diet must include daily food from the various food groups in sufficient amounts to meet the needs of an individual and to increase immunity. In developing countries, the most common cause of anaemia in pregnancy is nutritional. An inverse type of relationship indirectly exists between maternal nutritional status and fertility levels.

Dietary modification to increase consumption of micronutrient rich food in the safest and most sustainable long term strategy. However it needs an understanding of the food preferences and taboos of the community and involves behavioral modification changing attitudes and practices.

Good nutrition is very important for pregnant women. Deficiency of certain nutrients in the diet can lead to such adverse effects as anaemia and fetal neural tube defect. Considerable scientific evidence shows that diet is related to pregnancy outcome and frequency of complications demonstrating the important of good maternal nutrition, The U.S. Department of Agriculture administers a special Supplemental Nutrition Programme for women at nutritional risk who are pregnant or post-partum can obtain healthful food to supplement their diet.

Iron deficiency anaemia is the most widespread nutritional problem among women and has severe consequences for both their reproductive and productive roles. Maternal mortality rates are significantly higher among anaemic women.

Dietary factors play an important role in the development of iron deficiency. Although most habitually consumed diet of women in different regions of India. Other factors that contribute to anaemia are chronic blood loss due to hookworm infestation and malaria among women.

All the iron needed for the biological functions comes from diet. Although cereal pulse based diets are regarded as good sources of iron, the non-heme iron present is relatively poorly absorbed. In contrast, iron from red meat is highly available.

It is very common for women to develop iron deficiency during pregnancy. This is because your body needs extra iron so that your body has a sufficient blood supply and received all of the necessary oxygen and nutrient. Many pregnant women require an iron supplement, particularly from the 20th weeks of pregnancy.

The pregnant women iron deficiency anaemia to be caused solely by a lack of iron in their diet. Pregnant women may have to

increase the amount of iron rich food they consume during their pregnancy in order to help avoid iron deficiency anaemia.

If a dietary lack of iron among women though to be contributing to their deficiency anaemia. The women should eat:-

- Green leafy vegetables.
- Iron fortified bread.
- Beans.
- Nuts.
- Meat.
- Apricots.
- Prunes and
- Raisins.

To make sure that you have a healthy, well balanced diet, you should include foods from all the major food group in your diet, however those with iron deficiency anaemia should also make sure that they eat plenty of iron rich foods such as these listed above:-

In this chapter attempt shall be made to discuss the various health problems of the rural women as physical weakness among the rural women, anaemia among the rural women, malaria cases among the women, typhoid cases among the rural women, TB cases among

the women, high bleeding during delivery among the rural women, high bleeding, irritating behavior, breathing problem, uneasiness feeling, giddiness feeling, less working capacity of the women, weight loss, yellow nails of the women is very important symptom of anaemia, In this chapter we will discuss the nutritional diet of the respondents and in this chapter attempt shall be made to discuss the knowledge regarding good health, knowledge regarding balance diet, availability of balance diet after delivery, type of food intake and spicy food intake etc.

Table-5.1

Showing physical weakness of the respondents due to anaemia.

S. No.	Physical weakness	No. of respondents	Percentage
1	Yes	200	66%
2	No	100	34%
	Total	300	100%

Above table shows majority 66% of the respondents were suffering from physical weakness and 34% of the respondents do not have any physical weakness. Because of anaemia 66% of the respondents were suffering from anaemia due to imbalance diet after delivery. The main reason was lack of health knowledge, illiteracy, and poverty the main problem in study area. So the patient have no knowledge that what should she eat and she becomes anaemic.

Table:-5.2

Showing symptoms of anaemia among the respondents.

S. No.	Anaemia	No. of respondents	Percentage
1	Yes	145	48%
2	No	155	52%
	Total	300	100%

Above table shows that 52% of the respondents have no blood loss and 48% have blood loss among the total respondents. This can be attributed to the fact that roughly half of the total respondents were having anaemia.

In the village 48% women were anaemic so they have shown symptom which indicate that the women were anaemic. The main symptom of anaemia was yellow nail, physical weakness, shivering of the limbs, breathing problem, weight loss etc. These are the main symptoms of anaemia and villages women suffered from anaemia which was their main health problem.

Table:-5.3

Table showing the respondents who suffered from malaria disease.

S. No.	Malaria	No. of respondents	Percentage
1	Yes	105	35%
2	No	195	65%
	Total	300	100%

Above table indicates that 65% of the respondents did not suffer from malaria and 35% of the respondents suffered from malaria. Malaria is one of the diseases which create blood loss among the patients. 35% of the women suffered from malaria because of illiteracy, and poverty. They were not observing rules of hygiene, they were physically very weak due to anaemia so they were prone to other diseases.

Table:-5.4**Showing T.B. cases among respondents.**

S. No.	T.B.	No. of respondents	Percentage
1	Yes	6	2%
2	No	294	98%
	Total	300	100%

From above table it was evident that 98% of the respondents did not suffer from T.B. and 2% of the respondents were suffering from T.B. is also one of the diseases which may also create anaemia. The main cause of T.B. is unhygienic living, illiteracy, poverty. In rural area there are lack of many facilities so these types of disease become common though in this study very insignificant percentage suffered from T.B.

Table:-5.5

Showing high bleeding during delivery of the respondents.

S. No.	High bleeding	No. of respondents	Percentage
1	Yes	98	33%
2	No	202	67%
	Total	300	100%

Above table shows that 67% of the respondents were not having high bleeding and 33% of the respondents have high bleeding during delivery.

33% women suffered from high bleeding during delivery because they were not availed health facility. If health facilities were available which included monthly check up, education about proper diet then they should not have faced high bleeding during pregnancy.

Table:-5.6

Showing high bleeding (Hemorrhage) in the rural women.

S. No.	High bleeding	No. of respondents	Percentage
1	Yes	169	56%
2	No	131	44%
	Total	300	100%

Above table shows throws light that 56% of the respondents had high bleeding and 44% did not have bleeding. High bleeding in rural women was due to weakness.

Table:-5.7**Showing the irritating behaviour of the respondents.**

S. No.	Irritating Behaviour	No. of respondents	Percentage
1	Yes	51	17%
2	No	249	83%
	Total	300	100%

Above table indicates that 83% of the respondents did not have irritating behaviour and 17% of the respondents were found to have irritating behaviour.

Main reason of Irritating behavior in women was they were suffering from anaemia and have not much capacity to do anything and they were weak. They become anaemic because in study area there was lack of health facilities like monthly check-up, vaccination etc. This type of facilities is not easily available in study area and thus women have suffered from anaemia.

Table:-5.8**Table showing breathing problem.**

S. No.	High bleeding	No. of respondents	Percentage
1	Yes	180	60%
2	No	120	40%
	Total	300	100%

Above table shows that 60% of the respondents had breathing problem and 40% of the respondents were not having any breathing problem.

Breathing Problem in rural women in our study area was also due to weakness and weakness was due to iron deficiency and due to iron deficiency they have not much working capacity. If they did any hard work, they have breathing problem. Breathing problem is the result of Anaemia.

Table:-5.9**Showing the feeling of uneasiness**

S. No.	Uneasiness feeling	No. of respondents	Percentage
1	Yes	150	50%
2	No	150	50%
	Total	300	100%

Above table indicates that 50% of the respondents had feeling of uneasiness because of anaemia. 50% of rural women have not shown any sign of uneasiness feeling due to anaemia and feeling of uneasiness may not be attributed solely due to anaemia but it may be due to other reasons also.

Table:-5.10**Showing Giddiness feeling of the respondents.**

S.N.	Giddiness feeling	No. of respondents	Percentage
1.	Yes	168	55%
2.	No	132	44%
	Total	300	100%

Above table shows that 56% of the respondents had giddiness feeling and 44% of the respondents did not have any feeling of giddiness. Due to anaemia women suffered from giddiness because of anaemia different health problems increase automatically and giddiness feeling is one of the main problems among womens health problem. Anaemia means iron deficiency, blood loss and when in their body they have these deficiency of blood the problem increases.

Table-5.11

Showing working capacity of the respondents

S.No.	Working capacity	No. of respondents	Percentage
1	Yes	86	28%
2	No	214	72%
	Total	300	100%

From table no. 20 it can be seen that 72% of the respondents were found to be lacking in working capacity and 28% of the respondents have proper working capacity. 72% women have not working capacity because when she becomes pregnant she need extra care and diet and in the village due to illiteracy , poverty they were not able to afford the rich food and being illiterate she had no knowledge about diet. In this way she become weak and when she is weak the working capacity already is very less. So after delivery she did not have working capacity.

Table-5.12

Showing the weight losses of the respondents

S. No.	Weight losses	No. of respondents	Percentage
1	Yes	203	68%
2	No	97	32%
	Total	300	100%

From above table it can be seen that 68% of the respondents were having weight losses and 32% of the respondents did not have weight losses. Due to Imbalanced diet, high bleeding, , she had weight loss and during delivery she suffers from high bleeding and she did not take proper diet after delivery so she did not recover from this loss. In the village most of the women suffered from weight loss.

Table-5.13**Showing the yellow nails of the respondents**

S. No.	Yellow nails	No. of respondents	Percentage
1	Yes	165	55%
2	No	135	45%
	Total	300	100%

Above table shows that 55% of the respondents were having yellow nails and 45% of the respondents did not have yellow nails which is considered as a symptom of anaemia. Yellow nails are the main symptom of anaemia so when any women suffers from anaemia her nails become yellow. In the village mostly women have yellow nails due to anaemia and lack of iron deficiency.

Table-5.14

Showing the shivering of the limbs of the respondents

S. No.	Shivering	No. of respondents	Percentage
1	Yes	67	22%
2	No	233	78%
	Total	300	100%

Above table shows that 78% of the respondents did not have feeling of shivering and 22% of the respondents were suffering from shivering. Shivering of the limbs is also cause of the anaemia. When women becomes anaemic shivering of the limbs is common symptom.

Table-5.15

**Showing the knowledge regarding positive health of the
respondents**

S. No.	Knowledge regarding good health	No. of respondents	Percentage
1	Good body	177	59%
2	Beautiful person	34	12%
3	Fatty person	03	1%
4	Thin person	01	-
5	Physical, mental and social healthy person	85	28%
	Total	300	100%

Above table indicates that 59% of the respondents thought good physique is positive health, 28% of the respondents thoughts that physical, mental and social health is positive health 12% of the respondents thoughts that beauty is good health and 1% of the respondents thoughts that fat body is the sign of positive health. In this chapter it has been discussed that what is positive health, most of the rural women though that good body is positive health. Most of the women in the village were illiterate so they have no knowledge about the positive health and health education. Rural women are illiterate so they have no knowledge about positive health and nutritional diet.

Table-5.16

Showing the knowledge of Balance Diet of the respondents

S. No.	Knowledge	No. of respondents	Percentage
1	Food having compleate nutrition	84	28%
2	Heavy food	-	-
3	Tasty food	68	23%
4	Good food	148	49%
	Total	300	100%

From the above table it can be seen that majority 49% thoughts that good food was the balance diet while 28% thought that food which had necessary vitamins , carbohydrates , fats etc is the right food which can be balance diet. But this view was shared by only 28% of the respondents. While another 23% were of the opinion that tasty food was the balance diet.

Table-5.17

Showing availability of balance diet after delivery.

S. No.	Availability of balance	No. of respondents	Percentage
1	Yes	155	52%
2	No	145	48%
	Total	300	100%

Above table shows that 52% of the respondents have got balanced diet after delivery and 48% of the respondents did not get balanced diet after delivery. Lack of health knowledge, poverty one could not afford the rich food properly because rich food is costly and poor people could not purchase the food regularly because in the village most of people are poor but 52% women and their family members knew the importance of balance diet after delivery so they provided the women balanced and proper diet.

Table-5.18

Showing type of food intake.

S. No.	Type of food intake	No. of respondents	Percentage
1	Fresh food	20	6%
2	Stored food	-	-
	Both	280	94%
	Total	300	100%

From table 27 it can be observed that 94% of the respondents have taken both types of food that was fresh and stored. Majority of the respondents did not feel the importance of fresh food which may be the reason of there poor health status.

Table-5.19**Showing the habit of spicy food intake**

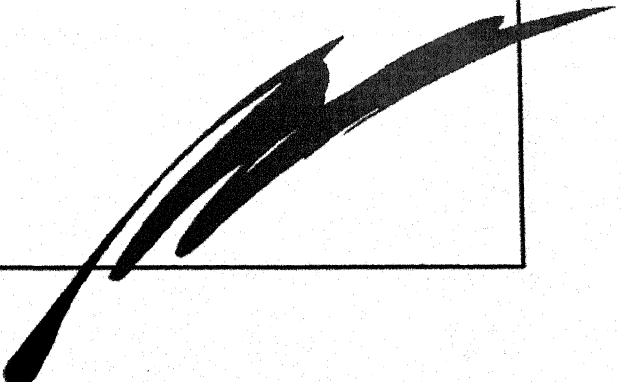
S. No.	Type of food intake	No. of respondents	Percentage
1	Yes	120	40%
2	No	180	60%
	Total	300	100%

Above table shows that 60% of the respondents did not intake spicy food and 40% of the respondents intake spicy food. Due to poverty the people can not include different type of variety in their food so they include very few varieties in their food but their food was very spicy because in village they have no knowledge about their health so they take spicy food daily, but some people have health knowledge therefore they did not take spicy food, which may be detrimental to health.



Chapter-6

*Socio-Economic, Psychological
And Cultural Factors
Leading to Anaemia*



*Chapter-6***SOCIO-ECONOMIC, PSYCHOLOGICAL AND CULTURAL FACTORS LEADING TO ANAEMIA**

In this chapter an attempt shall be made to study socio-economic, psychological and cultural factors of anaemia among the women.

A women's socio-cultural situation and her health are very closely inter-related. Earlier there was a tendency to view health purely in bio-medical terms, but there is an increasing awareness that a women's health is a product of the complex social, economic and cultural circumstances in which she lives. While these factors affect the health of all individuals, they affects women's health more. Some of the different socio-cultural factors affecting women's health are as follows financial status, education, religion, cultural mores, patriarchy, morbidity, and so on. Socio-cultural conditions are not just contributing factors but also consequences of women's health situation. A small example will illustrate reasons behind a woman undergoing repeated pregnancy and inability to bear sons, leads to a consequence where women have to face social alienation and even desertion.

In many societies, women are defined solely by their reproductive function. Women have no rights over their bodies or choice in their sexual activity. Economic and social factors of anaemia continue to ensure women's economic dependence on men often result in violence against women.

A major factor underlying anaemia among rural women is their low economic and social survival. If women have independent means they can often walk away from situations of abuse. Women's multiple roles as producers, home managers, mothers and community organizers are ignored.

The importance of reproductive activity is undervalued. By raising and caring for children, by preparing food and organizing the household, women ensure the sustenance of society and of the workforce necessary to carry out productive activities.

Social, economic and legal dependence is an extremely importance factor to be taken into account when women become anaemic to these reasons.

The undervaluing of women by the legal and economic structures of society has important consequences. Premature death is the most fatal consequences of the undervaluing of women. A

troubling statistic indicates that millions of women are missing in less developed countries owing to female feticide, female infanticide purposefully malnourishment and starvation.

Maternal mortality rates are significantly higher among anaemic women, as are prematurely and infant mortality rates. Although there is limited direct evidence concerning the effect of anaemia on women's physical work capacity, research on women shows a clear association between iron deficiency anaemia reduced work capacity. Because low-income, rural women living in the tropics experience the highest rates of iron deficiency anaemia along with other forms of malnutrition and morbidity, and also some physically demanding work responsibilities. It is probable that anaemia among women accounts for a significant loss of productivity.

Two aspects of the status of women appear particularly relevant as probable indirect determinants of their nutritional status. The first is cultural importance of childbearing in terms of a women's status and her fulfillment of family experience.

Food proscriptions also affect's women's nutritional status. Most societies have recommended dietary practices for pregnancy and lactation, and there is evidence from numerous cultures that meat and other high-protein food are withhold, sometimes from women in

general but most frequently from pregnant and lactating women. Women may themselves restrict their food intake during pregnancy to reduce fetal size and facilitate delivery. The effects of these practices on women's nutritional status are not known.

The lives of women in developing countries differ from those of men for cultural, biological and socio-economic reasons. These differences place women at significantly higher risk than men of malnutrition and mortality. The importance of women's nutrition of their own health and quality of life.

Studies in Punjab, India, shows that social discrimination against women in nutritional matters has persisted despite agriculture growth and economic development in the area. Even in privileged families, some women may be malnourished.

It is now acknowledge that malnutrition does not affect all members of a household equally, except in times of famine. Food is not equally, divided within households, but reflects the order of precedence and perceived social value of the consumers, as well as factors such as religious practices. Studies of food distribution in both developed and developing countries note that food distribution based on sex difference always favors males. Unequal food distribution is

further suggested by difference in morbidity and mortality within household.

Effective development intervention therefore require knowledge of household resource allocation patterns. This is important given the heavy borne baby poor women in both rural and urban setting.

Female labour is crucial for the production of men's cash crops. But it is now also vital that women desire a cash income is comparatively smaller then men's it is often more significantly in terms of families standard of living.

Most nutritional surveys in India monitor the status of households rather than that of individuals, bring the consumption unit which is based on norms rather than actual intake. One consumption unit is the recommended daily caloric intake of a male sedentary worker, and all other age-groups, sexes and activities levels are taken as a proportion of this measure. There as a proportion of this measure.

There is little evidence that Indian women actually receive even this proportion of the family's food resources.

In this chapter attempt shall be made to study monthly income according to family members , number of family members are employed, surviving according to family income, eating habits of the

women, women habit to take remaining food, intake of food after all family members, women believe not to take food just like her husband, fasting habit of the women, fasting habit during pregnancy, feeding habit of the women, breakfast habit of the women and timing of food intake..

Table-6.1**Showing monthly income according to family members**

S. No.	Income	No. of respondents	Percentage
1	Yes	75	25%
2	No	225	75%
	Total	300	100%

Above table shows that 75% of the respondent's monthly income was not low according to number of family members and 25% of the respondent's monthly income was low according to size of family members. Because the mostly families in study area were middle class families so their family income was not very low and they can afford and lead good quality of life. But significantly they were found to be anaemic.

Table-6.2

Showing employment status of family members.

S. No.	Employed	No. of respondents	Percentage
1	1	219	73%
2	2	75	25%
3	3	05	2%
4	Above 4	01	-
	Total	300	100%

Above table shows that 73% family have 1 member employed 25% families were having 2 members employed and 2% families had 3 members employed. In the studied village, size of the family was found to be large and employment status was poor, however very few families had both working members.

Table-6.3

Showing the survival according to the family income of the respondents

S. No.	Survival	No. of respondents	Percentage
1	Yes	155	52%
2	No	145	48%
	Total	300	100%

Above table shows that 52% of the respondents were surviving according to their family income and their monthly income was sufficient for their needs. While 48% found their survival difficult because of meagre family income.

Table-6.4

Showing the healthy eating habit of respondents

S. No.	Healthy eating habits	No. of respondents	Percentage
1	Yes	141	47%
2	No	159	53%
	Total	300	100%

Above table shows 53% of the respondents were not having healthy eating habit and 47% of the respondents had healthy eating habit. In the village it was found that cultural factor play great role and women take food after all family member had finished their food.

Some women take food only ones in whole day this is the important factor for their physical weaknesses. But the women and their family members ignore this factor.

Table-6.5

Showing women who take leftover food in the family

S. No.	Leftover food	No. of respondents	Percentage
1	Yes	35	12%
2	No	265	88%
	Total	300	100%

Above table shows that 88% of the respondents were not taking leftover food and 12% of the respondents were taking leftover food. Mostly villages women were illiterate so they don't know about their diet and poverty was also very important factor because due to poverty they could not afford the rich diet , however they were aware regarding consequences of stale food.

Table-6.6

Showing Habit Pattern of women regarding food intake.

S. No.	Habit Pattern	No. of respondents	Percentage
1	Yes	170	57%
2	No	130	43%
	Total	300	100%

Above table shows that 57% of the respondents took food after all family members finished their food and 43% of the respondents were not engaged in this pattern. Most of the women took food after their all family members because it was their cultural tendency and it could not be ignored. Because they thought that it was their duty. they should follow that rules and it was their tradition which they were taught in childhood.

Table-6.7

Table showing Belief of women regarding food.

S. No.	Eat food after the husband	No. of respondents	Percentage
1	Yes	295	99%
2	No	05	1%
	Total	300	100%

Above table indicates that 99% of the women believed that house lady should eat food after their husbands had taken their food.. It was their cultural pattern so they wanted to follow the cultural rules. In this way they ignored their diet and they loose their health slowly and she becomes anaemic and loose their energy. In the village most of the women have this tendency.

Table-6.8

Showing Equality of status in Food intake.

S. No.	Food intake just their husband	No. of respondents	Percentage
1	Yes	287	96%
2	No	13	4%
	Total	300	100%

Above table shows that 96% of the respondents took food just like their husbands and 4% of the respondents were not taking food just like their husband.

Table-6.9

Showing fasting habit of the respondents

S. No.	Fasting habit	No. of respondents	Percentage
1	Yes	293	98%
2	No	07	2%
	Total	300	100%

Above table throw light that 98% of the respondents were having fasting habit and 2% of the respondents did not have fasting habit. The rural area in India specially in Bundelkhand have a tendency that after marriage the women should eat food after their husband and she don't eat food before her husband. Due to this tendency women will not take the food timely and she eat rest of food because they were not in position to maintain their health and protect their health even she does not know that which type food she should eat.

Table-6.10

Showing the fasting habit during pregnancy

S. No.	Fasting habit	No. of respondents	Percentage
1	Yes	266	89%
2	No	34	11%
	Total	300	100%

Above table shows that 89% of the respondents were having fasting habit during pregnancy and 11% of the respondents were not having fasting habits during pregnancy.

Table-6.11

Showing the Breast Feeding Pattern.

S. No.	Feeding Period	No. of respondents	Percentage
1	6 month	9	3%
2	1 Year	144	48%
3	2 Year	105	35%
4	Above 2 Year	42	14%
	Total	300	100%

Above table shows the breast feeding pattern of the village women and duration of their breast feeding majority 48% breast fed their children upto 1 year of age followed by 35% who gave breast feeding to their children upto 2 years of age. This was a good tendency an healthy breast feeding pattern, which normally prevent another child birth.

Table -6.12

Showing the breakfast habit of the respondents

S. No.	Breakfast habit	No. of respondents	Percentage
1	Yes	78	26%
2	No	222	74%
	Total	300	100%

Above table shows that 74% of the respondents were not taking their breakfast and 26% of the respondents took their breakfast normally in the village women take their full food instead of breakfast.

Table-6.13

Showing frequency of food intakes

S.No.	frequency of food	No. of Respondents	Percentage
1	1 time	1	-
2	2 time	260	87%
3	3 time	39	13%
4	Above 4 times	-	-
	Total	300	100%

Above table shows that 87% of the women take their diet 2 times daily and 13% of the women took their diet 3 time daily.



Chapter-7

*Evaluation of Maternal
and Child health Services
and Various Welfare Schemes*



*Chapter-7***EVALUATION OF MATERNAL AND CHILD
HEALTH SERVICES AND VARIOUS
WELFARE SCHEMES**

In this chapter attempt shall be made to study evaluation of maternal and child health services and various welfare schemes for the women.

MCH (mother and child health) is not a new specialty it is a method of delivering health care to special group in the population which is especially vulnerable to disease, disability or death.

The MCH services encompass the curative, preventive and social aspects of obstetrics, family welfare, and nutrition.

The content of MCH care will vary according to demographic, social and economic pattern. Factor such as urbanization, rural migration, changing pattern of women's work and status.

MCH care is now conceived of as activities which promote health and prevent or solve health problems of mothers irrespective of whether they are curative, diagnostic, preventive or rehabilitative and whether they are carried out in health centers or in the home by primary health care workers, traditional dais, or highly trained specialists.

The mother and child health and family planning services were integrated in the forth five year plan for better effectiveness , they both are now an integral part of primary health care , which places emphasis on community participation and inter sectoral coordination.

Maternal and child health status is assessed through measurements of mortality, morbidity and growth and development. In many countries, mortality rate are still the only sources of information. Mortality data are scarce and poorly standardized. In recent years , attention has been paid to systematizing the collection , interpretation and dissemination of data and growth and development .The community used mortality indicators of MCH are -

- Maternal mortality rate
- Mortality in infancy and childhood
- Perinatal mortality rate
- Neonatal mortality rate
- Post-neonatal mortality rate
- Infant mortality rate
- 1-4 year mortality rate
- under 5 mortality rate
- child survival rate

Conventional MCH services tended to be fragmented into antenatal care, postnatal care, infant care, family planning etc. The various components were dealt with separately by different staff or departments. This integration is based on the fact that it is inconvenient for the mother to go to for care for her children and yet another for family planning services.

Apart from the 'risk approach' in MCH care one is willfully blind if one fails to acknowledge the millions of illegal abortion carried out every year , and thus resulting scores of thousands of deaths .

In this chapter attempt shall be made to discuss the various aspects like knowledge about ANM(Auxillary Nurse Midwife) , women who provided iron folic acid , knowledge about balance diet , vaccination facilities for the women during delivery , Vitamins provided for the women during delivery , healthy food intake during pregnancy by the women and health check-up during pregnancy.

Table – 7.1

Table showing knowledge about ANM.

S. No.	Knowledge about ANM	No. of respondents	Percentage
1	Yes	55	18%
2	No	245	82%
	Total	300	100%

Above table shows that 82% of the respondents were had no knowledge about ANM and 18% of the respondents have knowledge of ANM. On enquiry it was found that 82% of the women who did not have knowledge about ANM because this type of facility in which ANM visited the village was not available the most of the women were illiterate so they have no knowledge about ANM. Respondents were not aware of the role and function of ANM(Auxillary Nurse Midwife).

Table – 7.2**Showing the respondents who get Iron folic acid during pregnancy**

S. No.	Get Iron folic acid	No. of respondents	Percentage
1	Yes	71	24%
2	No	229	76%
	Total	300	100%

Above table shows that 76% of the respondents were getting Iron folic acid during pregnancy and 24% of the respondents were not getting Iron folic acid during pregnancy. Thus basic preventive services which may prevent Anaemia were not provided.

Table – 7.3

Showing the Knowledge about Balance Diet

S. No.	Knowledge about balance diet	No. of respondents	Percentage
1	Yes	59	20%
2	No	241	80%
	Total	300	100%

Above table shows that 80% of the respondents were not having knowledge about balance diet and 20% of the respondents had knowledge about balance diet. In the village no health worker come for the visit and nobody gave advise for the balance diet or any type of advise related to their health and the main cause was illiteracy most of the women in the village were illiterate so they have no self knowledge that what is balanced diet and what she should eat during pregnancy.

Table-7.4

Showing status of vaccination during pregnancy.

S. No.	Vaccination status	No. of respondents	Percentage
1	Yes	154	51%
2	No	146	49%
	Total	300	100%

Above table indicates that 51% of the respondents were vaccinated during pregnancy and 49% of the respondents were not vaccinated during pregnancy. In the present study it was found that very few women attended clinic or consulted doctor for health check-up. Despite medical college situated near by service of the ANM and other health worker were not available.

Table-7.5**Showing status of tetanus vaccination of the respondents**

S. No.	Tetanus vaccination	No. of respondents	Percentage
1	Yes	156	52%
2	No	144	48%
	Total	300	100%

Above table shows that 52% of the respondents had tetanus vaccination and 48% were not having tetanus vaccination. Due to lack of services women were not provided tetanus vaccination but those women who had health awareness accepted the vaccination.

Table-7.6**Showing knowledge of Vitamins by the respondents**

S. No.	Knowledge of Vitamins	No. of respondents	Percentage
1	Yes	24	8%
2	No	276	92%
	Total	300	100%

Above table shows that 92% of the respondents did not have knowledge of vitamins and 8% of the respondents got knowledge of the vitamins. Respondents did not realize the importance of vitamins therefore they were prone to Anaemia.

Table-7.7

**Showing views of respondents regarding healthy food intake
during pregnancy**

S. No.	Views of respondents	No. of respondents	Percentage
1	Yes	105	35%
2	No	195	65%
	Total	300	100%

From above table it can be seen that 65% of the respondents were not taking healthy food during pregnancy and 35% of the respondents were taking healthy food during pregnancy. The main cause in village was cultural factor so they have habit of taking leftover food and they have no knowledge that what should they eat and what should not ? In the village poverty was also main factor so they could not afford healthy food.

Table-7.8**Showing status of health check-up during pregnancy**

S. No.	Health check-up	No. of respondents	Percentage
1	Yes	161	54%
2	No	139	46%
	Total	300	100%

Above table shows that 54% of the respondents availed facility of health check-up during pregnancy and 46% of the respondents did not get health check-up facility during pregnancy. The health facility was easily available in the village because medical college was nearby situated. So the women availed facility and went in time for health check-up but those women who have no knowledge and her family members have no knowledge so they did not avail this facility.



Chapter-8

Brief Summary, Conclusion

And

Recommendation



Chapter-8

**BRIEF SUMMARY CONCLUSION AND
RECOMMENDATION**

This study was designed to investigate Social Economic & Psychological Factor leading to Anaemia among Rural Population Specially in Gumnawara. 8 km away from Jhansi city.

Among various nutritional disorders affecting women of child bearing ages allover the country is anaemia which occupies important position to cause widespread ill effects during pregnancy an its outcomes.

Anaemia for the purpose of this study is considered as a condition of reduction in the concentration of haemoglobin in the peripheral blood the normal for the age and sex.

Major objective of the study were.

To study the socio-economic and demographic characteristics of the rural women. Attempt was also made to assess the social-economic and psychological factors leading to anaemia besides; to identify the major health problems of the rural women and their nutritional status, study also covered the welfare schemes initiated for the rural women and to evaluate the MCH services provided by the government.

Study was carried out in a village Gumnawara 8 km. away from the Jhansi city. 300 women provided data for this study. These 300 were selected among 1500 women which were available in the village using simple random sampling. Women thus represented middle class and lower middle class families of the village

Socio-economic profile of women :

Majority of the respondents were in younger age group this was highly reproductive period, regards educational status majority was illiterate despite the area only 8 km away from the city literacy level was very lower. Village was dominated by backward caste followed by Dalits. Religion wise distribution of the respondent consisted of Hindus.

Gumnawara village was near Jhansi city hence majority of the respondents were engaged in business followed by agriculture majority of the women were house wives however few were engaged in activities like labour or other related work.

As regards the size of families. Majority was having large families and Majority of the families in the village were coming from poor socio-economic status. Study also covered the major health problem of the village women which were caused due to anaemia and their poor nutritional status.

It was found that majority of the respondents were suffering from physical weakness because of anaemia.

In the village most of the women were anaemic as they have symptoms like yellow nail, physical weakness, shivering of the limbs, breathing problems and weight loss etc. About 10% of the cases were referred to medical college and by Gynaecologist confirmed that these cases were acute anaemia.

There are many other disease which may lead to anemia among them malaria is also one of the dreadful disease among the respondents 35% had suffered from malaria.

Because of illiteracy and poverty they were suffering from anaemia and were prone to many diseases, besides, malaria tuberculosis is also a major disease which may cause anaemia it was heartening note the very insignificant percentage suffered from tuberculosis.

Excessive bleeding during delivery may also cause Anaemia 33% disclosed that they have suffered from excessive bleeding but majority 67% did not have excessive bleeding.

As regards hemorrhage 50% of the respondents have suffered from high bleeding this can be attributed to the weakness of the women.

Anaemia some times produces irritating behaviour. However this symptoms was not seen among the majority of the respondents but about 60% women have breathing problems.

Feeling of uneasiness was felt by 50% of the respondents through it can not be said that it was only due to anaemia but it may be due to other reasons.

Feeling of giddiness is also one of the symptom of anaemia it was felt by majority of the respondents to the tune of (55%).

Anaemia may reduce working capacity of the women. It was revealed by the respondents that working capacity was not reduced but 28% were of the opinion their working capacity has been reduced due to anaemia. Weight loss is also considered as one of the symptoms of anaemia the majority of the respondent opined that they have weight loss.

During investigation respondents were asked to show their nails the majority was having yellow nails. Similarly only very few respondents were having shivering of limbs.

Respondents were also asked about the concept of positive health majority was not conversant regarding positive health. In their opinion only good physique was sign of positive health.

Similarly views of the respondents were ascertained regarding balanced diet they have no knowledge of balanced diet and according to their opinion good and rich food was balanced diet.

Among the respondents 52% took balanced diet after pregnancy which included all the essential nutritional component. Remaining 48% could not afford balanced diet after delivery.

Mostly respondent took both types of food sometime fresh sometime stale. But it was a good sign that respondent were not interested in taking spicy food.

The main focus of the study was to study socio-economic and cultural factor which lead to anaemia. A women socio-cultural situation and her health are very closely inter related, studies in different parts of India have revealed that social discrimination against women in nutritional matters has persisted despite, agricultural development. Even women of high income group families were found to be malnourished.

In the village under study the income of the majority families was not found to be low according to the number of family member. But significantly despite having reasonable income, Women were found to be anaemic. In the village size of the family was found to be

large and employment status was poor very few families had working members. They were engaged in petty business and agriculture. Among the respondents 48% found their survival difficult because of low family income.

As regard eating habits of respondent majority did not have healthy food habit. Most of the respondents took their food after all family member had finished their food. As regard taking stale food majority was not aware regarding consequence of stale food. So for habit pattern of respondents regarding food intake was concerned as per cultural pattern they took their food when all family member had finished their food. Because it was a tradition which they learnt in childhood. It was a belief of respondents that they should take their food after their husbands have taken their food.

But in respect of food intake their was equality of status majority of the respondents while observing during fast did not know which type of food they should eat in order to maintain their health.

As regards breast feeding pattern it was hearting to know that majority of the respondents had breast fed their children upto 1 year of age. It was found in village that normally in the village women take full food instead of taking morning breakfast. Majority of the respondents took their meal 2 times daily.

Attempts was also made in the present study to evaluate the maternal and child health service and various welfare scheme provided to the women.

Maternal and child health status is assessed through measurement of mortality, morbidity and growth and development. In recent year attention has been paid systematizing the collection, interpretation and dissemination of data of growth and development.

In order to assess the prevailing MCH services in the village few indicators have been discussed like knowledge about ANMs roles, knowledge about balance diet, vaccination, vitamins provided during delivery, healthy food intake and health checkup during pregnancy.

As regards knowledge about ANM, respondent were not aware of the role and function of the ANM. The basic preventive health service like distribution of iron folic acid during pregnancy were not available which may prevent anaemia among the rural women.

Majority of the respondents did not have knowledge about balance diet. Vaccination status during pregnancy reasonably was found to be good because 51% village women were vaccinated. But about 40% have not availed this facility.

As regards the status of tetanus vaccination majority village women were given this vaccination. Particularly those women who had health awareness while 48% could not get this facility. Respondents did not realize the importance of vitamins therapy therefore they were found to be susceptible to the anaemia. Views of the respondents regarding healthy food intake during pregnancy were ascertained but majority did not realize the importance of healthy food intake. Therefore they were not taking healthy food during pregnancy. So for health check-up during pregnancy. It was found that majority of the respondents availed this facility while, another big percentage of 46[^] did not availed this facility.

SUGGESTION AND RECOMMENDATION

1. Among various nutritional disorders among child bearing ages were suffering from anaemia which was the cause of widespread ill effects during pregnancy. Diet and proper nutrition are important factor in the promotion and maintenance of good health among the women of studied area. A normal balanced diet was not available which was the main cause of anaemia.
2. There is a need to educate women regarding balanced diet which can be made available at the local level and which ensures nutritional adequacy.
3. Iron deficiency anaemia was one of the most common nutritional disorder in the village. Therefore there is a strong need to distribute iron, folic acid to the women of the area.
4. It was found the nearly two third of pregnant and one half of non-pregnant women were suffering from anaemia in the area. MCH service including curative, preventive and social aspect and proper health education should be provided.

5. A major factor underlying anaemia among the respondents was there low economic and social survival. If women have independent means they can often walk away from situation of abuse. Employment generating schemes among the women particularly through the self-help group can play a vital role to remove the incidence of anaemia.
6. socio-cultural condition like education, religion, food intake need to be changed. Repeated pregnancies and desire for a son because of which women have to face social alienation and even desertion. This needs to be avoided.
7. Social economic and legal dependence is extremely important these factors need to be taken into account due to these reasons women become anaemic.
8. Discrimination against women in nutritional matters is still persisting despite economic development in the area. Food was not equally divided with in house hold unequal food distribution should be avoided.
9. There is a need for changing dietary habits and providing nutritional education. Package of services should be given like immunization, prevention, treatment of anaemia antenatal care

and early identification of maternal complication deliveries by trained persannel and birth spacing are important areas which need to be taken care of by the health authorities of the area.

- 10.A sustained educational programme needs to be started in changing the dietary pattern and education regarding various socio-cultural factors which affect womens health should be provided.



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Schedule

साक्षात्कार / अनुसूची

ग्रामीण महिलाओं में रक्त अल्पता का सामाजिक एवं मनोवैज्ञानिक अध्ययन

1. उत्तरदाता का नाम : _____
2. उत्तरदाता के पति का नाम : _____
3. पता _____

4. आयु :-

1. 18-30 ☐ 2. 30-40 ☐ 3. 40-45 ☐ 4. 50 से अधिक ☐

5. शैक्षिक स्तर

1. अशिक्षित ☐ 2. शिक्षित ☐ 3. प्राइमरी ☐ 4. इण्टर ☐
5. स्नातक ☐ 6. अन्य ☐

6. जाति :-

1. सामान्य ☐ 2. पिछड़ी ☐ 3. दलित ☐ 4. अन्य ☐

7. धर्म :-

1. हिन्दू ☐ 2. मुस्लिम ☐ 3. सिक्ख ☐ 4. ईसाई ☐

8. पति का व्यवसाय :-

1. कृषि ☐ 2. श्रमिक ☐ 3. व्यापार ☐ 4. सरकारी नौकरी ☐

9. उत्तरदाता का व्यवसाय :

1. घरेलू महिला ☐ 2. कृषि ☐ 3. श्रमिक ☐ 4. स0 नौकरी ☐

10. परिवार में कुल सदस्यों की संख्या -

1. 3 ☐ 2. 4 ☐ 3. 5 ☐ 5. 5 से अधिक ☐

11. मासिक आय

1. 500-1500 ☐ 2. 1500-3000 ☐ 3. 3000-4500 ☐ 4. 4500 से अधिक ☐

12. क्या आपको कोई शारीरिक कमजोरी है ?

1. हाँ ☐ 2. नहीं ☐

13. क्या आप समझती हैं कि आपको खून की कमी है ?

1. हाँ ☐ 2. नहीं ☐

14. यदि हाँ तो आपको कमजोरी का अहसास कब होता है ?

1. कभी कभी ☐ 2. प्रायः ☐ 3. कुछ कह नहीं सकते ☐

15. क्या आपको कभी मलेरिया हुआ है ?

1. हाँ ☐ 2. नहीं ☐

16. क्या आपको कभी टाइफाइड हुआ है ?

1. हाँ ☐ 2. नहीं ☐

17. क्या आपको कभी टी0वी0 हुआ है ?

1. हाँ ☐ 2. नहीं ☐

18. क्या आपको प्रसव के दौरान अधिक रक्तस्राव हुआ है ?

1. हाँ ☐ 2. नहीं ☐

19. क्या आपको अधिक रक्तस्राव की शिकायत है ?

1. हाँ ☐ 2. नहीं ☐

20. क्या आपको प्रायः चिड़चिड़ाहट रहती है ?

1. हाँ ☐ 2. नहीं ☐

21. क्या आप अनुभव करती हैं कि आपकी साँस फूलती है ?

1. हाँ ☐ 2. नहीं ☐

22. क्या आपको घबराने की शिकायत होती है ?

1. हाँ ☐ 2. नहीं ☐

23. क्या आपको अक्सर चक्कर आते हैं ?

1. हाँ ☐ 2. नहीं ☐

24. क्या आप पहले की तरह ज्यादा काम कर पाती हैं ?

1. हाँ ☐ 2. नहीं ☐

25. क्या आपका वजन पहले से कम हुआ है ?

1. हाँ ☐ 2. नहीं ☐

26. क्या आपके नाखून पीले हैं ?

1. हाँ ☐ 2. नहीं ☐

✓ 27. क्या आपके हाथ-पैर चलने में काँपते हैं ?

1. हाँ ☐ 2. नहीं ☐

③ 28. क्या आपके घर की आय के हिसाब से घर में सदस्य अधिक हैं ?

1. हाँ ☐ 2. नहीं ☐

29. आपके घर में कितने लोग कमाने वाले हैं ?

1. 1 ☐ 2. 2 ☐

3. 3 ☐ 4. 3 से अधिक ☐

✓ 30. क्या आपके घर की आय में गुजारा हो जाता है ?

1. हाँ ☐ 2. नहीं ☐

31. क्या आप समय से भोजन करती हैं ?

1. हाँ ☐ 2. नहीं ☐

32. क्या आप घर के बचे हुए भोजन को खाकर ही काम चलाती हैं ?

1. हाँ ☐ 2. नहीं ☐

33. क्या आप घर के सभी सदस्यों के खाना खाने के बाद भोजन करती हैं ?

1. हाँ ☐ 2. नहीं ☐

34. क्या आप मानती हैं कि पुरुषों के खाना खाने के बाद महिलाओं को खाना खाना चाहिए।

1. हाँ ☐ 2. नहीं ☐

35. क्या आपको घर के पुरुषों की तरह भोजन दिया जाता है ?

1. हाँ ☐ 2. नहीं ☐

36. क्या आप उपवास आदि करती हैं ?

1. हाँ ☐ 2. नहीं ☐

37. क्या आप गर्भावस्था के समय उपवास करती हैं या थी ?

1. हाँ ☐ 2. नहीं ☐

38. आप अच्छे स्वास्थ्य से क्या समझती हैं ?

1. अच्छा शरीर ☐ 2. सुन्दर व्यक्ति ☐ 3. मोटा व्यक्ति ☐

4. दुबला व्यक्ति ☐ 5. शारीरिक मानसिक और सामाजिक रूप से स्वस्थ व्यक्ति ☐

39. आपने अपने बच्चे को किस उम्र तक दूध पिलाया है ?

1. 6 महीने ☐ 2. 1 साल ☐ 3. 2 साल ☐

4. 2 साल से अधिक ☐

40. आप भोजन किस प्रक्रिया से बनाती हैं ?

1. उबालकर ☐ 2. तलकर ☐ 3. भाप द्वारा ☐

4. उपरोक्त सभी से ☐

41. क्या आप सुबह का नाश्ता करती हैं ?

1. हाँ ☐ 2. नहीं ☐

42. यदि हाँ तो आप सुबह के नाश्ते में क्या लेती हैं ?

1. फल ☐ 2. तला हुआ भोजन ☐ 3. अंकुरित दालें ☐

4. दूध ☐ 5. चाय ☐ 6. अन्य ☐

43. आप दिन में कितने बार भोजन करती हैं ?

1. 1 समय ☐ 2. 2 समय ☐ 3. 3 समय ☐
4. 4 से अधिक ☐

44. आप संतुलित आहार से आप क्या समझती हैं ?

1. कैलोरी, प्रोटीन, वसा और कार्बोहाइड्रेट युक्त भोजन ☐
2. गरिष्ठ भोजन, ☐
3. स्वादिष्ट भोजन ☐
4. जो देखने में अच्छा हैं। ☐

45. संतुलित आहार में कौन सी वस्तुएँ सम्मिलित होती हैं ?

- | | हां | नहीं |
|----------------------------------|--------------------------|--------------------------|
| 1. अनाज | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. हरी सब्जियाँ और अन्य सब्जियाँ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. कन्दमूल फल | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. दूध | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. माँस मछली अंडा | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. शक्कर | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. वसा | <input type="checkbox"/> | <input type="checkbox"/> |

46. क्या आपको प्रसव के बाद संतुलित आहार मिला था ?

1. हाँ ☐ 2. नहीं ☐

47. आप किस तरह के भोजन का सेवन करती हैं ?

1. ताजा भोजन ☐
2. वासा भोजन ☐
3. दोनों तरह का भोजन ☐

✓ 48. क्या आप ज्यादा मिर्च मसाले युक्त भोजन का सेवन करती हैं ?

1. हाँ ☐ 2. नहीं ☐

⑤ 49. क्या आप प्रसाविका/ANM के बारे में जानती हैं।

1. हाँ ☐ 2. नहीं ☐

50. क्या प्रसाविका /ANM आपके घर में दौरा करने आती हैं या थी।

1. हाँ ☐ 2. नहीं ☐

51. क्या आपको गर्भावस्था के दौरान आयरन फोलिक एसिड दिया गया है या था ?

1. हाँ ☐ 2. नहीं ☐

52. क्या आपको संतुलित आहार के बारे में जानकारी दी गई थी या है ?

1. हाँ ☐ 2. नहीं ☐

53. क्या आपका गर्भावस्था के दौरान टीकाकरण हुआ है ?

1. हाँ ☐ 2. नहीं ☐

54. क्या आपको टिटनेस के टीके लगाये गये हैं ?

1. हाँ ☐ 2. नहीं ☐

55. क्या आपको विटामिन्स के बारे में बताया गया है ?

1. हाँ ☐ 2. नहीं ☐

56. क्या गर्भावस्था के दौरान आपको पोषाहार प्रदान किया गया है ?

1. हाँ ☐ 2. नहीं ☐

57. क्या गर्भावस्था के दौरान आपका स्वास्थ्य परीक्षण किया गया था या है ?

1. हाँ ☐ 2. नहीं ☐

58. क्या आपको गर्भावस्था के दौरान प्रसाविका द्वारा स्वास्थ्य विशेषज्ञों के पास भेजा गया था।

1. हाँ ☐ 2. नहीं ☐

59. आप मातृ एवं शिशु कल्याण की सेवाओं के बारे में क्या जानते हैं ?

प्रसव पूर्व सेवायें। ☐

प्रसव काल सेवायें। ☐

प्रसव उपरान्त सेवायें। ☐

परिवार कल्याण सेवायें। ☐

60. क्या आपको मातृ एवं शिशु कल्याण की सुविधायें दी गई थी।

1. हाँ ☐ 2. नहीं ☐

61. क्या आपके पास ऑगनवाड़ी कार्यकर्ता आती हैं।

1. हाँ ☐ 2. नहीं ☐

62. क्या ऑगनवाड़ी कार्यकर्ता ने स्वास्थ्य से संबंधित शिक्षा प्रदान की है।

1. हाँ ☐ 2. नहीं ☐

63. यदि हाँ तो किस तरह की शिक्षा प्रदान की है ?

1. स्वास्थ्य से सम्बन्धित शिक्षा ☐

2. बच्चे के रखरखाव से सम्बन्धित शिक्षा ☐

3. परिवार नियोजन की शिक्षा ☐

4. अन्य ☐

64. क्या आपके घर के पास फल सब्जियों उगाने के लिए स्थान उपलब्ध हैं।

1. हाँ ☐ 2. नहीं ☐

65. यदि हां तो आप रसोई बागवानी करने में इच्छुक हैं ?

1. हाँ ☐ 2. नहीं ☐

66. यदि हाँ तो आप किस प्रकार के फल सब्जियों के पौधे उगाना चाहेंगी।

1. पालक ☐ 2. लौकी ☐ 3. तरोई ☐
4. संतरा ☐ 5. अमरुद ☐ 6. पपीता ☐

67. क्या आपके यहां स्वास्थ्य से सम्बन्धित कोई समूह कार्यरत है।

1. हाँ ☐ 2. नहीं ☐

68. यदि हां तो क्या आप उस समूह की सदस्या हैं।

1. हाँ ☐ 2. नहीं ☐

69. यदि हाँ तो समूह ने आपकी किस क्षेत्र में मदद की है।

1. टीकाकरण ☐
2. अल्पवृत्तता के बचाव में ☐
3. स्वास्थ्य परीक्षण में ☐
4. स्वास्थ्य शिक्षा में ☐
5. परिवार नियोजन में ☐
6. आपात कालीन स्वास्थ्य सेवाओं में ☐
7. ANC रजिस्ट्रेशन में ☐
8. अन्य ☐

70. आपकी राय में ग्रामीण महिलाओं के उचित रख-रखाव के लिए किया जाना चाहिये।

1. महिलाओं को स्वयं प्रयास करना चाहिए। ☐
2. आयन फोलिक एसिड मुफ्त देना चाहिए। ☐
3. स्वास्थ्य शिक्षा देनी चाहिए। ☐
4. महिला शिक्षा पर दबाव डालना चाहिए। ☐
5. जोखिम भरा case में संवर्धन ☐
6. छोटे मोटे रोगों का इलाज ☐
7. अन्य ☐

दिनांक :-

स्थान :-

शोधकर्ता का नाम

अंकिता गुप्ता